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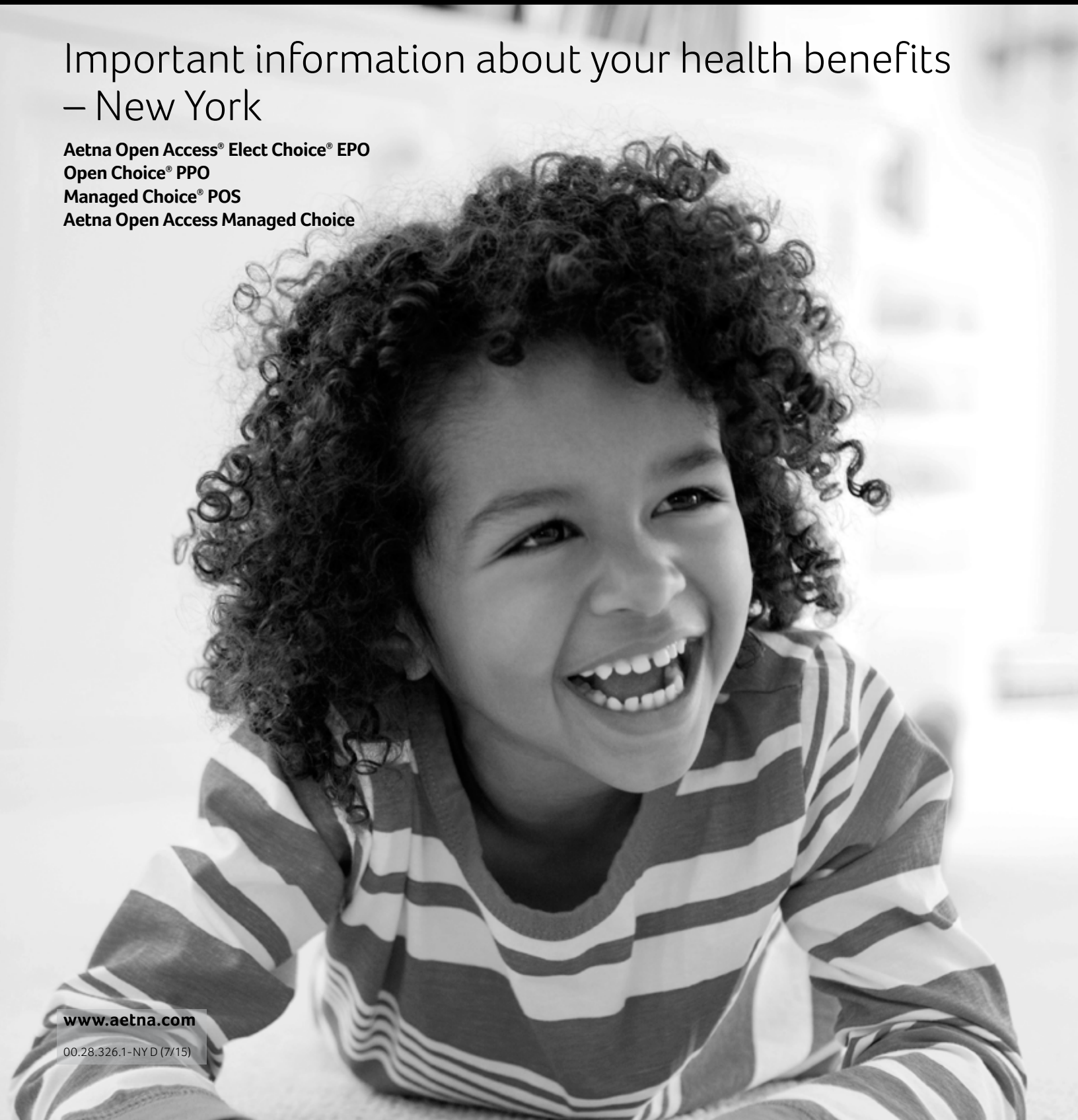
Important information about your health benefits – New York

Aetna Open Access® Elect Choice® EPO
Open Choice® PPO
Managed Choice® POS
Aetna Open Access Managed Choice



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Understanding your plan of benefits

Aetna* health benefits plans cover most types of health care from a doctor or hospital, but they do not cover everything. The plan covers recommended preventive care and care you need for medical reasons. It does not cover services you may want to have, like plastic surgery. It also does not cover treatment that is not yet widely accepted. You should also be aware that some services may have limits. For example, a plan may allow only one eye exam per year.

Have a Med Premier or Student Plan?
If you have a Student Accident and Sickness plan, please visit **www.aetnastudenthealth.com** for questions or call Aetna Student Health at the toll-free number on your ID card for more information.

If you have a Med Premier major medical plan and have questions, please call The Boon Group® at the toll-free number on your ID card for more information. The Med Premier plan is underwritten by Aetna Life Insurance Company. Administrative services are provided by Aetna Life Insurance Company and Boon Administrative Services, Inc., a licensed third party administrator and a wholly owned subsidiary of The Boon Group, Inc.

Not all of the information in this booklet applies to your specific plan
Most of the information in this booklet applies to all plans, but some does not. For example, not all plans have deductibles or prescription drug benefits. Information about those topics will only apply if your plan includes those provisions.

Where to find information about your specific plan
Your plan documents list all the details for your plan, such as what's covered, what's not covered and the specific amounts you will pay for services. Plan document names vary. They may include a Booklet-Certificate, Group Agreement and Group Insurance Certificate, Schedule of Benefits, Group Policy and/or any riders and updates that come with them.

If you can't find your plan documents, call Member Services to ask for a copy. Use the toll-free number on your Aetna ID card.

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

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.

Getting help

Contact Member Services with questions

Call the toll-free number on your ID card. Or, call **1-888-982-3862** Monday through Friday, 7 a.m. to 7 p.m. ET. You can also send Member Services an e-mail. Just go to your secure Aetna Navigator® member website at **www.aetna.com**. Click on "Contact Us" after you log in.

Member services representatives can help you:

- Verify or change personal information about your coverage.
- Answer benefits questions.
- Help you locate network providers.
- Find care outside your area.
- Advise you how to file a claim or check on a claim payment.
- Advise you on how to file complaints and appeals.
- Connect you to mental health services (if included in your plan).
- Find specific health information.
- Provide information on our Quality Management program, which evaluates the ongoing quality of our services.

You can also use the self-service features on your secure member website, which let you:

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

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

Use our DocFind® search tool for the most up-to-date list of health care professionals and facilities. You can 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 **1-888-982-3862**.

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
- Board certification status
- Language spoken
- Hospital affiliations
- Gender
- Driving directions

Transition of Care: We'll help you switch to a network doctor

If you have a condition that requires ongoing care, such as dialysis or chemotherapy, or if you're pregnant and have entered your second trimester, you may be able to keep seeing your current doctor with in-network coverage for a limited time after the effective date.

The program is for:

- **New members** – The program covers your out-of-network doctor for an additional 60 days after the plan's effective date. You must already be in an active course of treatment on the plan's effective date.
- **Members whose doctor leaves the network** – Your doctor must have left the network for reasons that are not 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. You may qualify to stay with your doctor for an additional 90 days after the effective date of the change.
- **For pregnant women** – If approved, you may continue to receive treatment from your current doctor for the remainder of your pregnancy – even through your postpartum care when it's directly related to the delivery.

To qualify, your out-of-network doctor must:

- Agree to accept our established rates as payment in full.
- Adhere to our quality assurance requirements.
- Provide us with necessary medical information related to your care.
- Adhere to our policies and procedures.
- Agree to these conditions before the start of the transitional period.

Costs and rules for using your plan

What you pay

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

- **Copay** – A set amount (for example, $15) you pay for a covered health care service. You usually pay this when you get the service. The amount can vary by the type of service. For example, you may pay a different amount to see a specialist than you would pay to see your family doctor.
- **Coinsurance** – Your share of the costs for a covered service. This is usually a percentage (for example, 20 percent) of the allowed amount for the service. For example, if the health plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20 percent would be $20. The health plan pays the rest of the allowed amount.
- **Deductible** – The amount you owe for health care services before your health plan begins to pay. For example, if your deductible is $1,000, you have to pay the first $1,000 for covered services before the plan begins to pay. You may not have to pay for some services.

  Other deductibles may apply at the same time:

  - **Inpatient Hospital Deductible** – Applies when you are a patient in a hospital
  - **Emergency Room Deductible** – The amount you pay when you go to the emergency room; waived if you are admitted to the hospital within 24 hours

  Note: These are separate from your general deductible. For example, your plan may have a $1,000 general deductible and a $250 emergency room deductible. This means you pay the first $1,000 before the plan pays anything. Once the plan starts to pay, you will pay the first $250 of your bill if you go to the emergency room.

Member payment estimator tool for New York members
If a service or procedure is not listed in the Member Payment Estimator tool in your secure member website, you can obtain an estimated cost by completing the appropriate Member Request for Estimate Form on our website. Please visit the state information section of Aetna.com at: **www.aetna.com/individuals-families/member-rights-resources/rights/state-specific-information.html** for the form to request a price estimate or to access a link to an online price estimate tool.

How we pay doctors and other health care providers

Doctors who participate in our network
Participating doctors are independent practicing physicians who are neither employed nor exclusively contracted with Aetna. Individual doctors and other health care providers are in the network by either directly contracting with us, or by affiliating with a group or organization that contracts with us.

There are several ways we pay doctors and other health care providers who are in the Aetna network:

- 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. We pay these organizations, which in turn may reimburse the doctor, 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.

Out-of-network services
Open Choice and Open Access Managed Choice plans: You may choose a doctor in our network, or go outside the network. We cover the cost of care based on if the provider, such as a doctor or hospital, is "in network" or "out of network."

Managed Choice plans: You may choose a doctor in our network, with or without a PCP referral. You may also go outside the network for your health care. We cover the cost of care based on your choices. You must get a PCP referral to visit in-network doctors to receive the highest level of benefits for specialty care. (See the "Referrals" section for more about this.) If you don't get a referral, your benefit will be paid at the "nonreferred" or "nonpreferred" level. This is the same level of benefits as if you went to an out-of-network doctor.

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

Your out-of-network doctor or hospital sets the rate to charge you. It may be higher — sometimes much higher — than what your Aetna plan "recognizes" or "allows." Your doctor may bill you for the dollar amount the plan doesn't "recognize." You'll also pay higher copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket limits. This means you are fully responsible for paying everything above the amount the plan allows for a service or procedure.

When you choose to see an out-of-network doctor, we pay for your health care depending on the plan you or your employer chooses. Some of our plans pay for out-of-network services by looking at what Medicare would pay and adjusting that amount up or down. Our plans range from paying 90 percent of Medicare (that is, 10 percent less than Medicare would pay) to 300 percent of Medicare (the Medicare rate multiplied by three). Some plans pay for out-of-network services based on what is called the "usual and customary" charge or "reasonable amount" rate. These plans use information from FAIR Health, Inc. (**www.fairhealth.org**), which is a not-for-profit company that reports how much providers charge for services in any Zip code.

When you choose to enroll in a plan with out-of-network coverage, you should consider how plans based on Medicare rates compare to plans based on "usual and customary" charges. Roughly speaking, in New York for all services combined, 300 percent of Medicare rates are the same as the "usual and customary" charges.

You can call Member Services at the toll-free number on your Aetna ID card to find out the method your plan uses to reimburse out-of-network doctors. You can also ask for an estimate of your share of the cost for out-of-network services you are planning. The way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. See "Emergency and urgent care" to learn more.

Using your plan

Choose a primary care physician

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

You can choose any PCP who participates in the Aetna network and who 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 provides routine preventive care and will treat you for illness or injury. Your PCP may refer you to other network doctors and hospitals for covered services and supplies. The PCP can also order lab tests and X-rays, prescribe medicines or therapies and arrange hospitalization.

Call the doctor's office directly to find out if it is accepting new patients.

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

You can change your PCP or specialist at any time
Log in at **www.aetna.com** or call the Member Services toll-free number on your Aetna ID card. The change will become effective when we receive and approve the request.

Making your specialist your 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 **1-888-982-3862**, to request these services.

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

You never need to get a referral if you have an Aetna Open Access Managed Choice, Aetna Open Access Elect Choice, or Open Choice plan. With the Managed Choice plan, you will receive the highest level of benefits under the plan when you get a referral from your PCP before you see a network specialist.

A "referral" is a written request for you to see another doctor. Some doctors can send the referral right to your specialist for you. There's no paper involved! Talk to your doctor to understand why you need to see a specialist. And remember to always get the referral before you receive the care.

Getting a referral from your PCP is not the same as getting approval (called "precertification") from the plan. Some health care services require both. For more information, read the "Precertification: Getting approvals for services" section of this booklet.

Remember these points about referrals:

- You do not need a referral for emergency care or urgent care.
- If you do not get a referral when required, the plan will pay for the service as an out-of-network benefit, if available.
- Your specialist might recommend treatment or tests that were not on the original referral. In that case, you may need to get another referral from your PCP for those services.
- Women can go to an Ob/Gyn without a referral. See "Direct access Ob/Gyn program" below.
- Referrals are valid for one year as long as you are still a member of the plan. Your first visit must be within 90 days of the referral issue date.
- Certain services, such as inpatient stays, outpatient surgery and certain other medical procedures and tests, require both a PCP referral and precertification. See the "Precertification" section for details.

Referrals within physician groups

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

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.

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 **1-888-982-3862**.

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.

You don't need a PCP referral for:

- Emergency care – See "Emergency care" section to learn more
- Urgent care – See "Emergency care" section to learn more
- Direct access services –Certain routine and preventive services do not require a referral under the plan when accessed in accordance with the age and frequency limitations outlined in the "What the Plan Covers" and the "Summary of Benefits" sections of your plan documents. You can directly access these network specialists for:
  - Routine gynecologist visits
  - Routine eye exams in accordance with the schedule
  - Annual screening mammogram for age-eligible women
  - Routine prenatal care (precertification may be required)

Precertification: Getting approvals for services

Sometimes we will pay for care only if we have given an approval before you get it. We call that "precertification" or "preauthorization." We usually only need to precertify more serious care like surgery or being admitted to a hospital. Your PCP or Aetna network doctor will get this approval for you. If the request is to go outside the network, you may have to get this approval yourself. To do so, call the precertification number on your Aetna ID card, or call Member Services. You must get the precertification before you receive the care.

Your plan documents list all the services that require you to get precertification. If you don't have a service precertified when required, you will have to pay for all or a larger share of the cost for the service.

We do not need to precertify emergency services.

We'll notify your doctor within three business days
If we have all the information necessary to review the request, we will make our decision and notify you (or your designee) and your doctor, by telephone and in writing, within three business days of receipt of the necessary information.

If we need more information, we will request it within 15 calendar days. You or your doctor will then have 45 calendar days to submit the information. If we receive the requested information within 45 days, we will make our decision and notify you (or your designee) and your doctor, by telephone and in writing, within three business days of our receipt of the information. If we do not receive all necessary information within 45 days, we will make our decision within 15 calendar days of the end of the 45-day period.

Timeframes for urgent care requests
If we have all information necessary to make a decision, we will do so and notify you (or your designee) and your doctor, by telephone and in writing, within 72 hours of receipt of the request. If we need more information, we will ask for it within 24 hours. You or your doctor will then have 48 hours to submit the information. We will make our decision and notify you and your doctor 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.

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 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.

Timeframe for inpatient substance use disorder treatment
If we receive a request for coverage of inpatient substance use disorder treatment at least 24 hours prior to discharge from an inpatient hospital admission, we will make our decision and notify you (or your designee) and your provider, by telephone and in writing, within 24 hours of our receipt of the necessary information. We will not deny coverage for the treatment while our decision is pending.

What we look for when reviewing a precertification request
First, we check to see that you are still a member. And we make sure the service is a covered expense under your plan. We also check that the service and place requested to perform the service is cost effective. If we know of a treatment or place of service that is just as effective but costs less, we may talk to your doctor about it.

We also look to see if you qualify for one of our case management programs. If so, one of our nurses may call to tell you about it and help you understand your upcoming procedure.

We follow up on services we precertify
There are other steps to our utilization review process. These include:

1. **Concurrent review:** We begin this process if your hospital stay lasts longer than what was approved for coverage. We make sure it is necessary for you to be in the hospital. We look at the level and quality of care you are getting. We will notify you or your doctor of our decision of whether to continue covering your hospital stay.

   Utilization review decisions for services during the course of care (concurrent reviews) will be made and notice provided to you (or your designee) or 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) or your provider, by telephone and in writing, within the earlier of: (a) one business day of the receipt of necessary information, or (b) the end of the time period allotted to provide the clinical information.

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

   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 s/he is released from the inpatient facility.

3. **Retrospective review:** We review the claim for services after you are discharged. We may look over your medical records and claims from your doctors and the hospital. We look to see that you received appropriate care and if there was any waste or unnecessary costs. We may deny coverage if the information presented is materially different from what was originally presented during the precertification process. If we deny coverage, we will tell you and your doctor within 30 days.

   If we need additional information, we will request it within 30 calendar days. You or your doctor will then have 45 calendar days to provide the information. We will make a determination and provide notice to 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.

   If we have all the necessary information and fail to make a determination within the applicable time frames, you may consider this a denial and file an appeal. See the "Appeals" section for details.

   To contact the Utilization Review Agent, call **1-888-982-3862** weekdays from 8 a.m. to 4 p.m ET. After hours, you can leave a message. If your doctor has a question about your coverage, he or she may call or write to our Patient Management department at the address or phone number on your Aetna ID card.

   We may deny coverage for a previously precertified treatment, service or procedure if:

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

If we deny a claim

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. All final adverse determinations will be made by a clinical peer reviewer who was not involved in the original denial.

All denials will be in writing. The notice will include:

- The reasons for the denial, including reference to specific plan provisions on which the determination is based and the clinical rationale, if any
- A description of our review procedures, including a statement of your rights to bring a civil action
- Instructions how to start the appeals, expedited appeals and external appeals process (as applicable) 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, if applicable
- The claim amount (if applicable), and a statement of the availability, upon request, of the diagnosis and treatment codes and their meaning
- Notice that you may request the clinical review criteria used to deny the request. This notice will also specify any additional information we may need to make a decision on your appeal.

Your doctor can ask us to reconsider a denial if we did not attempt to communicate with him or her first

For precertification and concurrent reviews, your doctor can request a "reconsideration review." We will reconsider the denial within one business day. If we uphold the denial, we will notify you and your doctor in writing with appeal instructions. See "What to do if you disagree with us" to learn more.

We follow specific rules to help us make your health a top concern during our reviews

- We do not reward Aetna employees for denying coverage.
- We do not encourage denials of coverage. In fact, we train staff to focus on the risks of members not getting proper care.

How to file 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.

Information about specific benefits

General conditions for coverage

For a service or supply to be covered, it must be:

- Included as a covered expense in your plan documents and not be listed as an excluded expense
- Within any maximums and limitations outlined in your plan documents
- Obtained in accordance with all the terms, policies and procedures outlined in your plan documents

The plan will pay for covered medical expenses, up to the maximums, as shown in your Certificate of Coverage. You are responsible for any costs over the maximum limits or any noncovered health care procedures treatments or services as outlined in your Certificate of Coverage.

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, that a prudent layperson possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

1. 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
2. Serious impairment of such person's bodily functions
3. Serious dysfunction of any bodily organ or part of such person
4. 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 acting 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." You can get urgent care from your PCP or an urgent care facility. If you're 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

We'll review the information when the claim comes in. If we think the situation was not emergent, we might ask you for more information and may send you a form to fill out. Please complete the form, or call Member Services to give us the information over the phone. Emergency care expenses that are not related to an emergency medical condition are excluded and are your financial responsibility.

Follow-up care for plans that require a PCP

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

After-hours care

You may call your doctor's office 24 hours a day, 7 days a week if you have medical questions or concerns. You may also consider visiting participating urgent care facilities.

Prescription drug benefit

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

Some plans encourage generic drugs over brand-name drugs

A generic drug is the same as a brand-name drug in dose, use and form. They are FDA approved and safe to use. Generic drugs usually sell for less; so many plans give you incentives to use generics. That doesn't mean you can't use a brand-name drug, but you'll pay more for it. You'll pay your normal share of the cost, and you'll also pay the difference in the two prices.

We may also encourage you to use certain drugs

Some plans encourage you to buy certain prescription drugs over others. The plan may even pay a larger share for those drugs. We list those drugs in the Aetna Preferred Drug Guide (also known as a "drug formulary"). This list shows which prescription drugs are covered on a preferred basis. It also explains how we choose medications to be on the list.

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

You can view our preferred drug guide at **www.aetna.com/formulary**, or get a printed copy by calling the Member Services toll-free number on your Aetna ID card.

You might not have to stick to the list

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

You may have to try one drug before you can try another

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

Some drugs are not covered at all

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

New drugs may not be covered

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

Get a copy of the preferred drug guide

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

Drug companies may give us rebates when our members buy certain drugs

We may share those rebates with your employer. Rebates usually apply to drugs on the preferred drug list. They may also apply to drugs not on the list. In plans where you pay a percentage of the cost, your share of the cost is based on the price of the drug before Aetna receives any rebate. Sometimes, in plans where you pay a percentage of the cost instead of a flat dollar amount, you may pay more for a drug on the preferred drug list than for a drug not on the list.

Mail-order and specialty-drug services from Aetna owned pharmacies

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

Have questions? Get answers.

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

Mental health and addiction benefits

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

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

You can access most outpatient therapy services without a referral or precertification. But it's a good idea to check with Member Services first. If we deny a claim for mental health services, you may appeal our decision according to the terms of your health plan. See "What to do if you disagree with us" for details.

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

Aetna Behavioral Health offers two screening and prevention programs for our members
- **Beginning Right® Depression Program:** Perinatal and Postpartum Depression Education, Screening and Treatment Referral
- **SASADA Program:** Substance Abuse Screening for Adolescents with Depression and/or Anxiety

Call Member Services to learn more about these programs.

Transplants and other complex conditions

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

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**.

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**.

Knowing what is covered

Avoid unexpected bills. Check your plan documents to see what's covered before you get health care. Can't find your plan documents? Call Member Services to ask a specific question or have a copy mailed to you.

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

We check if it's "medically necessary"

"Medically necessary" means the service or supply is provided by a doctor who exercises 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:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate in accordance with generally accepted standards of medical practice in terms of type, frequency, extent, site and duration, and considered effective for the illness, injury or disease
- Not primarily for your convenience or that of your treating physician
- Not more costly than an alternative service or sequence of services that is at least as likely to produce the same or similar therapeutic or diagnostic results

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. For example some benefits are limited to a certain number of days, visits or a dollar maximum. Refer to your plan documents and Schedule of Benefits for the plan limits and maximums.

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 reward Aetna employees for denying coverage. Sometimes a physician's group will determine medical necessity. Those groups might use different resources than we do.

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

We study the latest medical technology

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

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

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

We publish our decisions in our Clinical Policy Bulletins.

We post our findings on www.aetna.com

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

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

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

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

What to do if you disagree with us

Grievances

Please tell us if you are not satisfied with a response you received from us or with how we do business. A "grievance" is a complaint that does not involve a claim that was denied because it was not medically necessary. It does apply to contractual benefit denials, issues or concerns you have about our administrative policies, or access to doctors.

Here is a summary of the grievance processes.

Call the toll-free number on your Aetna ID card to file a verbal grievance or to ask for the address to mail a written grievance. You can also e-mail Member Services through the secure member website or write to us at the address on your Aetna ID card. If you're not satisfied after talking to a Member Services representative, you can ask us to send your issue to the appropriate department.

You or your designee may file a grievance up to 180 calendar days from when you received the decision you are asking us to review. 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, we need from you.

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.

Time frames for determining a grievance
Qualified personnel will review your grievance in a timely manner. 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 time frames:

Type of grievance	Level 1 appeals
Expedited/Urgent grievance	By phone within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of the grievance. We will provide written notice within 72 hours of receipt of your grievance.
Preservice grievance (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 grievance (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 or request for service)	In writing, and depending on your plan, either within 30 or 45 calendar days of receipt of your grievance, or within 45 calendar days of receipt of all necessary information, but no more than 60 calendar days of receipt of your grievance. See your plan documents for timeframes that apply to your specific plan.

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.

See your plan documents to learn about the process to submit a grievance or an appeal.

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. You may file an urgent appeal by phone. You have up to 60 business days from receipt of our decision to file an 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. If necessary, it will also inform you of any additional information we may need to make a decision. One or more qualified personnel at a higher level than the person who rendered the complaint decision will review the appeal. If it is a clinical matter, a clinical peer reviewer will look into it.

If we fail to make a decision of your appeal after receiving the necessary information and within the required time frames, we will consider your appeal approved.

Time frames for determining your appeal of a grievance determination:

Type of grievance	Level 1 appeals
Expedited/Urgent grievance	The earlier of 2 business days of receipt of all necessary information or 72 hours of receipt of your appeal
Preservice grievance (A request for a service or treatment that has not yet been provided)	15 calendar days of receipt of your appeal
Postservice grievance (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 or request for service)	Depending on your plan, either 30 business days of receipt of all necessary information to make a determination, or 30 calendar days of receipt of your appeal. See your plan documents for timeframes that apply to your specific plan.

If you are not satisfied or if you need help
If you are not satisfied with our appeal determination, or at any other time you are dissatisfied, you may 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
One Commerce Plaza
Albany, NY 12257
www.dfs.ny.gov

If you need help 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**
www.communityhealthadvocates.org

Internal appeals for utilization review determinations

See "We follow up on services that we precertify" under "Precertification: Getting approvals for services" to understand "utilization review."

You, your designee and, in retrospective cases, your doctor, may request an internal appeal if we deny a previously precertified service or make other adverse determinations based on utilization review. You may submit your appeal by phone, in person or in writing.

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 and, if necessary, inform you of any additional information needed before we can make a decision. 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.

Out-of-network service denial
You 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 provier 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. The statement must say 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

Out-of-network referral denial
You have the right to appeal the denial of a request for a referral; an authorization to a nonparticipating provider when we determine that 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. For a utilization review appeal of an out-of-network referral denial, 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. The statement must:

- Say the participating provider recommended by us does not have the appropriate training and experience to meet your particular health care needs for the health care service.
- Recommend a nonparticipating provider with the appropriate training and experience to meet your particular health care needs and who is able to provide the requested health care service.

First level appeal

Precertification appeal
If your appeal relates to a service that requires prior approval and the services have not yet been rendered, we will decide the appeal within 15 calendar days of receipt of the appeal request.

Retrospective appeal
If your appeal relates to a retrospective claim, we will decide the appeal within 30 calendar days of receipt of the appeal request.

Expedited appeal
An appeal of a review 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. An expedited appeal is not available for retrospective reviews. For an expedited appeal, 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. An expedited appeal will be determined within the earlier of 72 hours of 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.

Substance use appeal
If we deny a request for inpatient substance use disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission, and you or your provider file an expedited internal appeal of our adverse determination, we will decide the appeal within 24 hours of receipt of the appeal request. If you or your provider file the expedited internal appeal and an expedited external appeal within 24 hours of receipt of our adverse determination, we will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal appeal and external appeal is pending.

Second level appeal

If you disagree with the first level appeal determination, you or your designee can file a second level appeal. You or your designee can also file an external appeal. The four-month timeframe for filing an external appeal begins on receipt of the final adverse determination on the first level of appeal. By choosing to file a second level appeal, the time may expire for you to file an external appeal.

A second level appeal must be filed within 60 days of receipt of the final adverse determination on the first level 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 and inform you, if necessary, of any additional information needed before a decision can be made.

If your appeal relates to a service that requires prior approval and the services have not yet been rendered, we will decide the appeal within 15 calendar days of 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.

Getting help with your appeal

If you need help filing an appeal, you may 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**
www.communityhealthadvocates.org

If your doctor thinks you cannot wait, you can request an expedited appeal

If you are not satisfied with the resolution of an expedited appeal, you may file a standard internal appeal or an external appeal. You may file an expedited external appeal at the same time you file an expedited internal appeal. See the “External review” section for more.

External review

Get a review from someone outside Aetna

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

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, unless:
  - We agree in writing to waive the internal appeal. We are not required to agree to your request to waive the internal appeal.
  - You file an external appeal at the same time 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 that 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).

Your right to appeal 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 the "External appeal" section above.

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 as stated above. Your attending physician must certify your condition or disease falls under one of these categories:

- Standard health services are ineffective or medically inappropriate.
- There does not exist a more beneficial standard service or procedure covered by your plan.
- There exists a clinical trial or rare disease treatment (as defined by law).

Your attending physician must also recommend one of the following:

- A service, procedure or treatment for which 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 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.

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 file an external appeal if you meet the two requirements for an external appeal as stated above, and your doctor has requested precertification for the out-of-network treatment.

Your attending physician must also certify all of the following:

- The out-of-network service is materially different from the alternate recommended in-network health service.
- Based on two documents from available medical and scientific evidence, the out-of-network service is likely to be more clinically beneficial than the alternate in-network treatment.
- 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 out-of-network services if the requested health care service is available in network.

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 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.

How to file an external appeal

You may appoint a representative to help you with your application. If you do so, the Department of Financial Services may ask you to confirm in writing that you have appointed the representative.

You have four months after receiving a denial or waiver of the internal appeal process to file a written request for an external appeal. If you are filing an external appeal because we failed to adhere to claim processing requirements, you have four months from such failure to file a written request for an external appeal.

To file an external appeal:

1. Request an external appeal application from the New York State Department of Financial Services at **1-800-400-8882**.
2. Complete the external appeal application. We enclosed an application with the denial letter or with the 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** or write to:

   The Department of Financial Services
   Consumer Assistance Unit
   1 Commerce Plaza
   Albany, New York 12257
3. Submit the completed application to the Department of Financial Services at the address shown on the application. You can include any additional documentation you feel is relevant. If you meet the criteria for an external appeal, the state will forward the request to a certified external appeal agent.

The Department of Financial Services will review your request

1. An initial reviewer will make sure you are eligible for an external appeal. You or your doctor must release all pertinent medical information concerning your medical condition and request for services. After the initial reviewer deems your request as eligible, he or she will randomly assign it to an external appeals agent. All external appeals will be conducted by clinical peer reviewers.
2. If 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 so we can 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. In the case of an expedited appeal (described below), we do not have a right to reconsider our decision.
3. The external appeal agent will make a decision within 30 days of receiving your completed application. The external appeal agent may request additional information from you, your physician or Aetna. In that case, the agent will have five additional business days to make his or her decision. The agent must notify you in writing of the decision within two business days.

You may request an expedited review if:

- Your doctor certifies that a delay in providing the denied service poses a serious threat to your health, or that the standard external appeal time frame would seriously jeopardize your life, health or ability to regain maximum function.
- You received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay.

For an expedited review, the external appeal agent must make a decision within 72 hours of receiving your completed application. Immediately after reaching a decision, the external appeal agent must try to notify you and Aetna by telephone or fax of that decision. The external appeal agent must also notify you in writing of his or her decision.

You may file an expedited external appeal at the same time you file an expedited internal appeal.

If the external appeal agent approves the request or overturns our decision
We will provide coverage subject to the other terms and conditions of the plan. 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 non-experimental or non-investigational 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.

If your request is for services you are currently receiving
Your doctor may not charge you for services the external appeals agent determines is not medically necessary, except to collect a copayment.

Fees for external appeals
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.

Member rights and responsibilities

Know your rights as a member

You have many legal rights as a member of a health plan. You also have many responsibilities. You have the right to suggest changes in our policies and procedures. This includes our Member Rights and Responsibilities.

Some of your rights are below. We also publish a list of rights and responsibilities on our website. Visit **www.aetna.com/individuals-families/member-rights-resources.html** to view the list. You can also call Member Services at the number on your ID card to ask for a printed copy.

You have the right to complete and current medical information
This includes a diagnosis, treatment and prognosis from a doctor or other health care provider in terms you can reasonably be expected to understand. When it is not advisable to give such information to you, the information will be made available to an appropriate person acting on your behalf.

You have the right to refuse treatment
You may refuse treatment to the extent permitted by law and be informed of the medical consequences of that action.

You have the right to create an advance directive
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 – name the person you want to make medical decisions for you.
- Living will – spells out the type and extent of care you want to receive.
- Do-not-resuscitate order – states that you don't want CPR if your heart stops or a breathing tube if you stop breathing.

You can create an 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, 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.

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**.

Anyone can get health care

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

We must comply with these laws:

- Title VI of the Civil Rights Act of 1964
- Age Discrimination Act of 1975
- Americans with Disabilities Act
- Laws that apply to those who receive federal funds
- All other laws that protect your rights to receive health care

How we use information about your race, ethnicity and the language you speak
You choose if you want to tell us your race/ethnicity and preferred language. We'll keep that information private. We use it to help us improve your access to health care. We also use it to help serve you better. See "We protect your privacy" to learn more about how we use and protect your private information. See also "Anyone can get health care."

Your rights to enroll later if you decide not to enroll now

When you lose your other coverage
You might choose not to enroll now because you already have health insurance. You may be able to enroll later if you lose that other coverage or if your employer stops contributing to the cost. This includes enrolling your spouse or children and other dependents. If that happens, you must apply within 31 days after your coverage ends (or after the employer stops contributing to the other coverage).

When you have a new dependent
Getting married? Having a baby? A new dependent changes everything. And you can change your mind. You can enroll within 31 days after a life event if you chose not to enroll during the normal open enrollment period. Life events include:

- Marriage
- Birth
- Adoption
- Placement for adoption

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

More information is available upon request

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

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 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 Superindendent of Insurance provided that such requirements are promulgated pursuant to the state administrative procedure act
13. If you are scheduled to receive health care services, you can ask us if that health care provider participates in the plan's network
14. With respect to out-of-network coverage, you can receive the approximate dollar amount the plan 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)

Out-of-network reimbursement examples for group coverage

This summary gives examples of typical costs for out-of-network services under our three most commonly sold health insurance plans in New York County that include Zip codes with the prefix 100, 101 and 102. If you want details about your coverage and costs, you can get the complete terms in the policy or plan document by calling **1-888-982-3862**.

Colonoscopy (Biopsy of large bowel using an endoscope) CPT Code: 45380 Anesthesia CPT Code: 00810 Pathology CPT Code: 88305				
Sample care costs:	**UCR**	**Plan* [A]**	**Plan [B]**	**Plan [C]**
Hospital services	$6,200	$1,225	$1,750	$2,626
Physician services	$1,900	$314	$599	$898
Anesthesia	$1,333	$132	$252	$378
Pathology	$244	$84	$159	$239
Total	**$9,677**	**$1,755**	**$2,760**	**$4,141**
Patient pays:				
Deductibles**		$0	$0	$0
Copays		$0	$0	$0
Coinsurance		$702	$1,104	$1,656
Difference between UCR and what the plan pays		$7,922	$6,917	$5,537
Total		**$8,624**	**$8,021**	**$7,193**

Laminotomy (Partial removal of bone with release of spinal cord or spinal nerves of one interspace in lower spine) CPT Code: 63030 Anesthesia CPT Code: 00630				
Sample care costs:	**UCR**	**Plan* [A]**	**Plan [B]**	**Plan [C]**
Hospital services	$19,799	$6,657	$9,510	$14,265
Physician services	$23,884	$1,214	$2,312	$3,468
Anesthesia	$1,728	$212	$403	$605
Total	**$45,411**	**$8,083**	**$12,225**	**$18,338**
Patient pays:				
Deductibles**		$0	$0	$0
Copays		$0	$0	$0
Coinsurance		$3,233	$4,890	$7,355
Difference between UCR and what the plan pays		$37,328	$33,186	$27,073
Total		**$40,561**	**$38,076**	**$34,428**

Breast reconstruction (Insertion of tissue expander in breast) CPT Code: 19357 Anesthesia CPT Code: 00402				
Sample care costs:	**UCR**	**Plan* [A]**	**Plan [B]**	**Plan [C]**
Hospital services	$15,928	$8,059	$11,513	$17,270
Physician services	$16,500	$1,866	$3,555	$5,333
Anesthesia	$1,230	$132	$252	$378
Total	**$33,658**	**$10,057**	**$15,320**	**$22,981**
Patient pays:				
Deductibles**		$0	$0	$0
Copays		$0	$0	$0
Coinsurance		$4,023	$6,128	$9,192
Difference between UCR and what the plan pays		$23,601	$18,338	$10,677
Total		**$27,624**	**$24,466**	**$19,869**

UCR (usual and customary cost) is the amount providers typically charge for a service. This chart uses UCR based on FAIR Health at the 80th percentile for New York County Zip codes with the prefix 100. Your provider may bill more than UCR.

Patient pays represents sample cost-sharing. Your cost-sharing may vary.

*** Plans are as follows:**
Plan A = 105% Medicare for professional services, and 140% Medicare facility services
Plan B = 200% Medicare for professional services, and 200% Medicare facility services
Plan C = 300% Medicare for professional services, and 300% Medicare facility services

** Assumes deductible has been met.

Note: Colonoscopy provided out of network is not covered under the Affordable Care Act as a preventive service. Copayment is shown as $0 because copayments do not apply to out-of-network coverage. These examples do not take into account whether or not the member's coinsurance limit has been met.

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 1-888-982-3862.
Si usted necesita este material en otro lenguaje, por favor llame a Servicios al Miembro al 1-888-982-3862.

www.aetna.com

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