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

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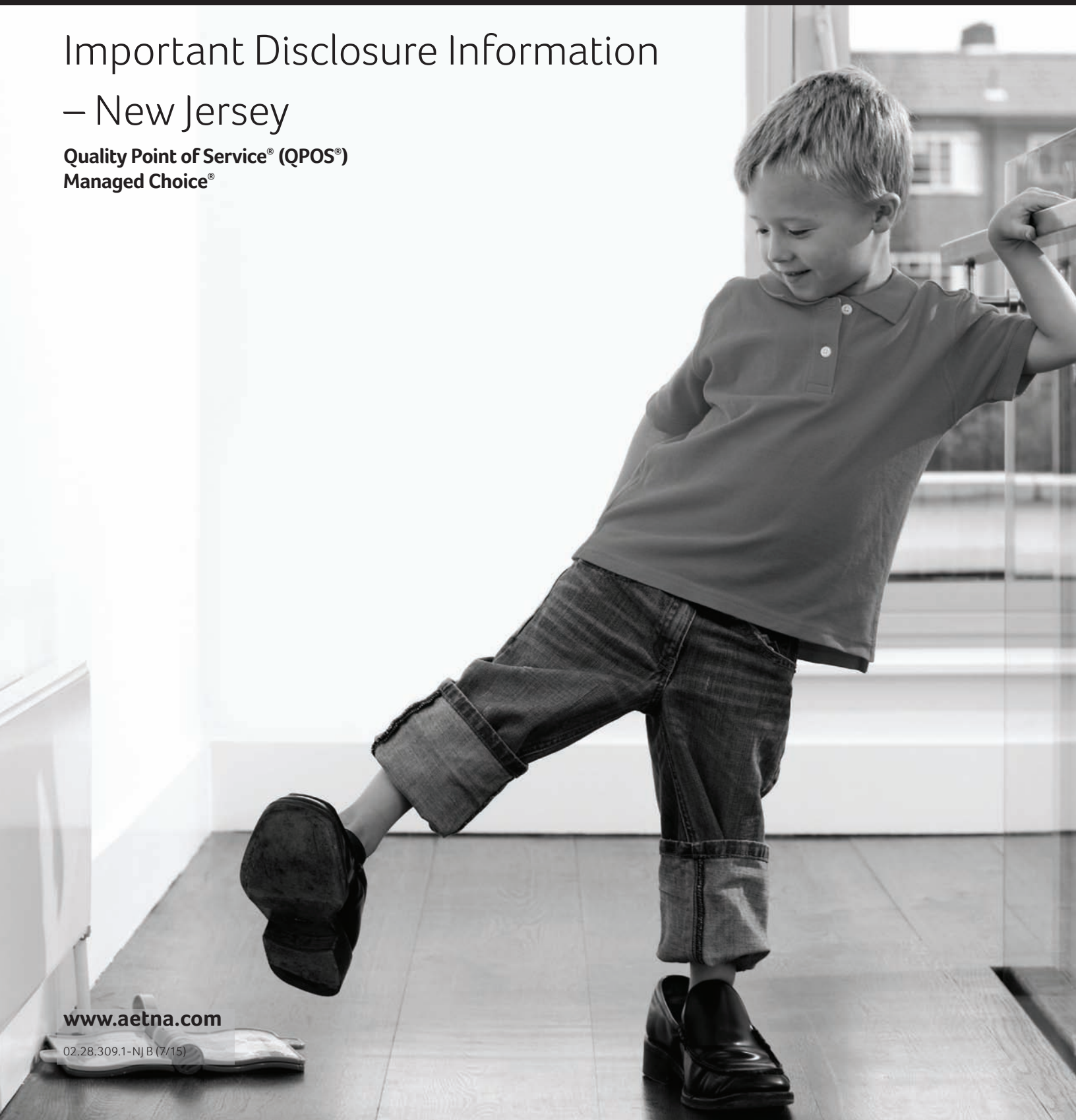
Important Disclosure Information – New Jersey

Quality Point of Service® (QPOS®)
Managed Choice®



www.aetna.com

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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 just want to have, like plastic surgery. It also does not cover treatment that is not yet widely accepted. You should also be aware that some services may have limits. For example, a plan may allow only one eye exam per year.

Not all of the information in this booklet applies to your specific plan

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

Where to find information about your specific plan

Your "plan documents" list all the details for the plan you choose. This includes what's covered, what's not covered and what you will pay for services. Plan document names vary. They may include a Booklet-Certificate, Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Group Insurance Policy and/or any riders and updates that come with them.

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

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

Get plan information online and by phone

If you're already enrolled in an Aetna health plan

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

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

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

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

   Then you can log in any time to:

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

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

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

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

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

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

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

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

   You can also speak with a representative to:

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

Not yet a member?

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

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

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

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

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

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

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

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

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

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

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

Physician board certification
77.3 percent of our participating physicians are board certified. If you would like to know if a specific physician is board certified or is currently accepting new patients, please call the Member Services number listed on your ID card. You can even get driving directions to the office. If you don't have Internet access, call Member Services to ask about this information.

Appointment waiting times
Our standard customary waiting times for PCP appointments for urgent care is to be seen the same day or within 24 hours. Routine care (nonurgent) is divided into three categories as: Preventive care it is the expectation to be seen within 8 weeks; Symptomatic care is to be seen within 3 days; and Routine care is to be seen within 7 days.

Get a FREE printed directory

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

Costs and rules for using your plan

What you pay

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

- **Copay** – A set amount (for example, $25) you pay for a covered health care service. You usually pay this when you get the service. The amount can vary by the type of service. For example, you may pay a different amount to see a specialist than you would pay to see your family doctor.
- **Coinsurance** – Your share of the costs for a covered service. This is usually a percentage (for example, 20 percent) of the allowed amount for the service. For example, if the health plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20 percent would be $20. The health plan pays the rest of the allowed amount.
- **Deductible** – The amount you owe for health care services before your health plan begins to pay. For example, if your deductible is $1,000, you have to pay the first $1,000 for covered services before the plan begins to pay. You may not have to pay the deductible for some services.

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, if you go to the emergency room you will pay the first $250 of that bill.

Your costs and how we pay providers

With QPOS and Managed Choice plans, you may choose a doctor in our network with or without a PCP referral. You may also choose to visit an out-of-network doctor. We cover the cost of care based on your choices.

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

We pay doctors who are in our network on a discounted fee-for-service basis. This is the amount used when determining your percentage share if your plan includes "coinsurance." Any charge for a service or supply furnished by a participating provider in excess of such provider's negotiated charge for that service or supply will not be a covered expense under the group contract. In no event will you or your eligible dependents be expected to pay any such excess charge. It will be the responsibility of Aetna and the participating provider to resolve the amount deemed to be excess.

"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 use an out-of-network doctor.

Your out-of-network doctor or hospital sets the rate to charge you. It may be higher — sometimes much higher — than what your Aetna plan "recognizes" or "allows." Your doctor may bill you for the dollar amount that 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., a not-for-profit company, that reports how much providers charge for services in any ZIP code.

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

How your plan covers out-of-network services at an in-network hospital
Even when you are admitted to an in-network hospital, if an out-of-network doctor provides care during your confinement, the cost of that doctor's care will be covered at the out-of-network level of benefits, subject to the applicable out-of-network copayments, coinsurance and deductibles. This also applies to lab work, imaging and other services provided during your stay.

If your plan includes prescription drug benefits
Aetna Pharmacy Management negotiates discounts from independent pharmacies, chain pharmacies and mail-order vendors that participate in the Aetna network. The reimbursement formula is based on average wholesale price (AWP) less a negotiated discount, plus a dispensing fee. (There is no dispensing fee for mail-order vendors.) The dispensing fee is a contractual fee negotiated between Aetna Pharmacy Management and the network pharmacy.

Paying primary care providers for quality
Some PCPs are paid more when their offices score high for performance. The scores are based on these factors:

- Member satisfaction
- Percentage of members who visit the office every year
- Medical record reviews
- The burden of illness of the members who have selected the PCP
- How well they manage chronic illnesses like asthma, diabetes and congestive heart failure
- Whether they accept new patients
- Whether they submit claims and referrals electronically

We encourage you to ask all your doctors how they are paid for their services.

If you need more information about how we pay primary care physicians or any other provider in our network, please contact us at the toll-free number or address on your Aetna ID card or write to: Aetna Health Inc., 55 Lane Road, Fairfield, NJ 07004. Not yet a member? Call **1-888-982-3862**.

Choose a primary care physician

With an Aetna Point of Service (POS) plan, you are covered at different levels depending on whether you visit your chosen primary care provider (PCP), or if you go directly to any licensed physician without seeing your PCP first.

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

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

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

Tell us who you choose 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.

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

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

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

Remember these points about referrals:

- You do not need a referral for emergency care.
- If you do not get a referral when required, you may have to pay the bill yourself. If your plan lets you go outside the network, the plan will pay it as an out-of-network benefit.
- Your specialist might recommend treatment or tests that were not on the original referral. In that case, you may need to get another referral from your PCP for those services.
- Women can go to an Ob/Gyn without a referral. See "PCP and referral rules for Ob/Gyns" 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.

Your doctor must tell you if he or she has a financial interest when making a referral

Doctors, chiropractors and podiatrists are allowed to refer you to other health care providers where they have a financial interest. New Jersey law requires them to tell you when they do. You can contact your doctor to learn more about this. Call **1-973-504-6200** or **1-800-242-5846** if you believe your doctor is not giving you this information.

PCP and referral rules for obstetricians and gynecologists (Ob/Gyn)

Female members can choose an Ob/Gyn as her PCP. Women can also go to any Ob/Gyn who participates in the Aetna network without a referral or prior authorization. Visits can be for:

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

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

Precertification: Getting approvals for services

Sometimes we will pay for care only if we have given an approval before you get it. We call that "precertification." You usually only need precertification for more serious care like surgery or being admitted to a hospital. When you get care from a doctor in the Aetna network, your doctor gets precertification from us. But if you get your care outside our network, you must call us for precertification when that's required.

Your plan documents list all the services that require you to get precertification. If you don't, you will have to pay for all or a larger share of the cost for the service. Even with precertification, you will usually pay more when you use out-of-network doctors.

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

You do not have to get precertification for emergency services.

What we look for when reviewing a request

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

Precertification does not verify if you have reached any plan dollar limits or visit maximums for the service requested. So, even if you get approval, the service may not be covered.

Our review process after precertification (Utilization Review/Patient Management)

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

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

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

Information about specific benefits

Coverage for children

You may include children who do not live with you on the plan. The child does not have to live in the same service area as you. But, the child must follow the same plan rules you must follow. For example, this is a network-only plan. Your child must use doctors and hospitals for the network service area where he or she lives.

Dependent coverage to age 31
The federal age limit for children is 26 years. In New Jersey, you may include children on your plan up to age 31. You and your child must meet all other eligibility requirements. Talk to your employer or read your plan documents to learn more. You can also call Member Services at the number on your Aetna ID card.

Emergency and urgent care and care after office hours

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

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

- Call 911 or go to the nearest emergency room. If you have time, call your doctor or PCP.
- Tell your doctor or PCP as soon as possible afterward. A friend or family member may call on your behalf.

You do not have to get approval for emergency services.

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

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

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

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

After-hours care – available 24/7
Call your doctor when you have medical questions or concerns. Your doctor should have an answering service if you call after the office closes. You can also go to an urgent care center, which may have limited hours. To find a center near you, log in to **www.aetna.com** and search our list of doctors and other health care providers. Check your plan documents to see how much you must pay for urgent care services.

Prescription drug benefit

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

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

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

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

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

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

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

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

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

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

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

Have questions? Get answers.

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

Mental health and addiction benefits

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

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

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

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

Call Member Services to learn more about these programs.

Transplants and other complex conditions

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

Important benefits for women

Women's Health and Cancer Rights Act of 1998
Your Aetna health plan provides benefits for mastectomy and mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between breasts; prosthesis; and treatment of physical complications of all stages of mastectomy, including lymphedema. Coverage is provided in accordance with your plan design and is subject to plan limitations, copays, deductibles, coinsurance and referral requirements, if any, as outlined in your plan documents.

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

No coverage based on U.S. sanctions

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

Knowing what is covered

You can 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"

Medical necessity is more than being ordered by a doctor. "Medically necessary" means your doctor ordered a product or service for an important medical reason. It might be to help prevent a disease or conditio, or to check if you have one. Or it might be to treat an injury or illness.

The product or service:

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

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

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

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.

Claim procedures

Network doctors file claims for you. If you do need to file a claim, you can get the form online. Just log in to your secure member website at **www.aetna.com**. You can also call Member Services at the number on your ID card to ask for a form. The claim form includes complete instructions, like what documentation to send with it.

You'll need the itemized bill with your Aetna ID number clearly marked on it. Send everything to the address shown on your Aetna ID card. We pay claims according to the Claim Payment Procedure section of the Certificate of Coverage.

We will make a decision on your claim. For urgent care claims and preservice claims, we will notify you by mail of our decision, whether paid or not. For other types of claims, we may only notify you if we make an "adverse determination."

Adverse benefit determinations are decisions that result in denial, reduction, or termination of a benefit or the amount paid for it. It also means a decision not to provide a benefit or service. Adverse benefit determinations can be made for one or more of the following reasons:

- The service or supply is not medically necessary, is an experimental or investigational procedure, or is for dental or cosmetic purposes.
- The service or supply is not covered by the plan. A service or supply is not covered if it is not included in the list of covered benefits.
- It is excluded from coverage.
- You have reached a coverage limit.
- You or your dependents are not eligible to be covered by the plan.

Only a medical doctor can make an adverse benefit determination.

We will notify you in writing according to the time frames shown below. Under certain circumstances, we may extend these time frames. The notice will explain how you can appeal the adverse benefit determination. Please see the Complaints and Appeals section for more information about appeals.

The chart below summarizes some information about how different types of claims are handled.

Aetna time frame for notifying you that we denied a claim	
Type of claim	**Aetna response time from receipt of claim**
Urgent care claim – A claim for medical care or treatment where a delay could seriously jeopardize your life or health, your ability to regain maximum function; or subject you to severe pain that cannot be adequately managed without the requested care or treatment	As soon as possible but not later than 72 hours
Preservice claim – A claim for a benefit that requires approval of the benefit before getting medical care.	Within 15 calendar days
Concurrent care claim extension – A request to extend a course of treatment that we previously approved	If an urgent care claim, as soon as possible but not later than 24 hours; Otherwise, within 15 calendar days
Concurrent care claim reduction or termination – Decision to reduce or terminate a course of treatment that we already approved. We will not deny coverage based on medical necessity for previously approved services unless the approval was based on material misrepresentation or fraudulent information submitted by the covered person or provider.	With enough advance notice to allow the member to appeal
Postservice claim – A claim for a benefit that is not a preservice claim	Within 30 calendar days

What to do if you disagree with us

Complaints, appeals and external review

We have procedures you can follow if you are not satisfied with a decision we have made or with our operations. The procedure depends on the type of issue or problem you have.

- Appeal – An appeal is a formal request that we reconsider an adverse benefit determination. The appeal procedure has two levels.
- Complaint – A complaint is an expression of dissatisfaction about quality of care or our operation.

This chart summarizes how we handle appeals for different types of claims:

Aetna time frame for responding to an adverse benefit determination appeal		
Type of claim	**Aetna response time from receipt of appeal**	
	Level one appeal	Level two appeal
Urgent care claim – A claim for medical care or treatment where a delay could seriously jeopardize your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without the requested care or treatment	Within 36 hours Our review will be provided by someone who was not involved in making the adverse benefit determination.	Within 36 hours Review provided by Aetna Appeals Committee
Preservice claim – A claim for a benefit that requires approval before getting medical care	Within 5 business days Our review will be provided by someone who was not involved in making the adverse benefit determination.	Within 15 calendar days Review provided by Aetna Appeals Committee
Concurrent care claim extension – A request to extend or a decision to reduce a previously approved course of treatment	Treated like an urgent care claim or a preservice claim depending on the circumstances	Treated like an urgent care claim or a preservice claim depending on the circumstances
Postservice claim – Any claim for a benefit that is not a preservice claim	Within 5 business days Our review will be provided by someone who was not involved in making the adverse benefit determination.	Within 20 business days Review provided by Aetna Appeals Committee

A. Complaints
If you are dissatisfied with the administrative services you receive from us or you want to complain about a network doctor, call or write to Member Services within 30 calendar days of the incident. Please include a detailed description of the matter and copies of any records or documents you think are relevant to the matter. We will review the information and provide you with a written response within 30 calendar days of the receipt of the complaint. The response will explain what you need to do to seek an additional review. If we need more information, our review may take longer.

B. Appeals of adverse benefit determinations
We will send written notice of an adverse benefit determination. The notice will include the reason for the decision, and it will explain what steps to take if you wish to appeal. The notice will also identify your rights to receive additional information that may be relevant to an appeal. Requests for an appeal must be made in writing within 180 calendar days from the date of the notice. However, level-one appeals may also be requested orally.

You or your doctor acting on your behalf and with your consent may appeal if you are not satisfied with an adverse benefit determination.

We provide for two levels of appeal. You must complete both levels of review before pursuing an appeal to an independent utilization review organization (IURO) or bringing a lawsuit against us, unless serious or significant harm has occurred or will imminently occur to you. If you decide to appeal to the second level, the request must be made in writing within 60 calendar days from the date of our notice from the level-one appeal. That notice will explain your right to make a level-two appeal. We will acknowledge the appeal in writing within 10 business days of receipt of a level-two appeal.

- The level-one appeal review will be conducted by a doctor who was not the original reviewer nor a subordinate of the original reviewer who rendered the initial adverse benefit determination.
- For a level-two appeal, we will conduct a same or similar specialty review for appeals involving clinical issues. The consulting practitioner or professional will be someone who was not involved in the original determination.

We maintain a formal appeal process (level-two) if you or your doctor acting on your behalf and with your consent are not satisfied with the results of a level-one appeal. You'll have the opportunity to pursue your appeal before a panel of physicians and/or other health care professionals we select. The professional will not have been involved in any of the previous decisions. You and/or your authorized representative may attend the level-two appeal hearing and question the Aetna representatives and present your case.

C. Exhaustion of Process
You are not required to exhaust internal appeals before complaining to the Department of Banking and Insurance. The Department of Banking and Insurance's ability to investigate a complaint will also not be limited by any exhaustion.

In the event that we fail to comply with any of the deadlines to complete the level-one or level-two appeal, or if we, for any reason, expressly waive our rights to an internal review of any appeal, then you and/or your doctor may go directly to the external appeals process as follows.

D. External Appeal Process
If you or your doctor acting on your behalf and with your consent are not satisfied with the result of the level-one and level-two appeal process above, you may pursue your appeal to an independent utilization review organization (IURO) as outlined below.

Except as explained in section C, your right to an external appeal under this section is contingent on your full compliance with both stages of our level-one and level-two appeal processes.

Within four months from receipt of the written determination of the level-two appeal panel, you or your doctor acting on your behalf and with your consent must file a written request with the Department of Banking and Insurance. You can download a copy of the "Application for the Independent Health Care Appeals Program" from **www.state.nj.us/dobi/index.html**. Or you can call Member Services to have us mail a request form to you. You will also have to sign a general release for all medical records pertinent to the appeal. Mail your request to:

New Jersey Department of Banking and Insurance
Consumer Protection Services Office of Managed Care
Attn: IHCAP
PO Box 329
Trenton, NJ 08625-0329
Courier: 20 West State Street

You will have to pay a $25 filing fee, payable by check or money order to the Department of Banking and Insurance. If you are experiencing financial hardship, the fee may be reduced to $2. You can demonstrate financial hardship if you also receive Pharmaceutical Assistance to the Aged and Disabled, Medicaid, NJ FamilyCare, General Assistance, SSI, or New Jersey Unemployment Assistance.

Upon receipt of the appeal, the executed release and the appropriate fee, the Department of Banking and Insurance will immediately assign the appeal to an IURO.

Upon receipt of the request for appeal from the Department of Banking and Insurance, the IURO will conduct a preliminary review of the appeal and accept it for processing if it determines:

- You are or were a member of Aetna.
- The service that is the subject of the complaint or appeal reasonably appears to be a covered benefit under the Certificate of Coverage.
- You have fully complied with both the level-one and level-two appeal processes.
- You have provided all information required by the IURO and the Department of Banking and Insurance to make the preliminary determination. That information includes the appeal form, a copy of any information provided by us regarding our decision to deny, reduce or terminate the covered benefit, and a fully executed release to obtain any necessary medical records from us and any other relevant health care provider.

Once the IURO completes the preliminary review, it will immediately notify you and/or your doctor in writing as to whether the appeal has been accepted for processing and the reasons if it was not accepted.

If the IURO accepts the appeal for processing, it will conduct a full review to decide if you were deprived of medically necessary covered benefits as a result of our decision. The IURO will have taken into consideration:

- All pertinent medical records, consulting physician reports, and other documents submitted by the parties
- Any applicable, generally accepted practice guidelines developed by the federal government and national or professional medical societies, boards and associations
- Any applicable clinical protocols and/or practice guidelines we have developed

The full review referenced above will initially be conducted by a registered, professional nurse or physician licensed to practice in New Jersey. When necessary, the IURO will refer all cases for review to a consultant physician in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the appeal. All final recommendations of the IURO will be approved by the medical director of the IURO.

The IURO will complete its review and issue its recommended decision as soon as possible in accordance with the medical exigencies of the case. Except as provided for in this subsection, that will not exceed 30 business days from receipt of all documentation necessary to complete the review. The IURO may, however, extend its review for a reasonable period of time as may be necessary due to circumstances beyond its control. In such an event, the IURO will send written notice to you, to the Department of Banking and Insurance and to Aetna before concluding its preliminary review. The notice will indicate the status of the review and the specific reasons for the delay.

If the IURO determines you were deprived of medically necessary covered benefits, it will recommend to you, Aetna, and the New Jersey Department of Health and Senior Services the appropriate covered health care services you should receive.

Once the review is complete, we will abide by the decision of the IURO.

The filing fee shall be refunded to the covered person or health care provider if the final internal adverse benefit determination is reversed by the IURO.

E. Record Retention

We shall retain the records of all complaints and appeals for a period of at least 7 years.

F. Fees and Costs

Except as set forth in section D. above for an external appeal, nothing herein shall be construed to require us to pay counsel fees or any other fees or costs you incur in pursuing a complaint or appeal.

G. Addresses and Phone Numbers

For Aetna Health Inc.:

Aetna Complaints and Appeals
PO Box 14596
Lexington, KY 40512

Call the toll-free number on your member ID card. If you don't have your card, call us at **1-888-872-3862** and a representative will transfer you to the correct Member Services area.

For New Jersey Department of Banking and Insurance:

Office of Managed Care Consumer Protection Services
PO Box 329
Trenton, NJ 08625-0329
1-888-393-1062

For Aetna Life Insurance Company:

Aetna Complaints and Appeals
151 Farmington Avenue
Hartford, CT 06156

You may also call the toll-free number on your ID card.

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, including our Member Rights and Responsibilities.

Below are just some of your rights. We also publish a list of rights and responsibilities on our website. Visit **www.aetna.com/individuals-families/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:

- Available and accessible services when medically necessary, including availability of care 24 hours a day, 7 days a week for urgent or emergency conditions. For urgent or emergency conditions, call 911 or go to the nearest emergency facility.
- Be treated with courtesy and consideration, and with respect for your dignity and need for privacy
- Be provided with information about our policies and procedures for products, services, health care providers, appeals and other information about us and the care you receive from your doctors
- Choose a primary care physician within the limits of the covered benefits and availability and included as a participating health care professional in the plan network
- A choice of specialists among participating network doctors when you receive an authorized referral, subject to the doctor's availability to accept new patients
- Request and receive a list of participating doctors in the Aetna network, including addresses, telephone numbers and languages spoken
- Get help and referral to doctors with experience in treating patients with chronic disabilities
- Receive from your doctors, in terms you understand, an explanation of your complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives whether they are covered benefits or not. If you are not capable of understanding the information, your doctor must explain it to your next of kin or guardian and document it in your medical record.
- Pay your copayments, coinsurance and/or deductible as outlined in your plan, without any additional bill from in-network doctors for amounts above the plan's "recognized" charge
- Formulate and have advance directives implemented
- All the rights afforded by law or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language you understand
- Prompt notification of termination or changes in benefits, services or provider network
- File a complaint or appeal with Aetna or the Department of Banking and Insurance (20 West State Street, 9th Floor, PO Box 329, Trenton, NJ 08625-0329, Main phone: **1-609-292-5316**, Fax: **1-609-292-5865**) and to receive an answer to those complaints within a reasonable period of time

Independent consumer satisfaction surveys

You can get the results of an independent consumer satisfaction survey and an analysis of quality outcomes of health care services of managed care plans in the State of New Jersey. For a copy of the guide, call **1-888-393-1062**, or write the New Jersey Department of Banking and Insurance, PO Box 325, Trenton, NJ 08625-0325. You can view or download a copy of the HMO Performance Report at no charge from the Department's website at: **www.state.nj.us/dobi/index.html**.

New Jersey QUITNET and New Jersey QUITLINE

Tobacco products pose a serious health threat in New Jersey and cost the health insurance industry millions of dollars each year. The New Jersey Department of Health and Senior Services has two free services that can help you kick the tobacco habit.

- **New Jersey Quitline** – Call **1-866-NJ-STOPS** or **1-866-657-8677** for individualized telephone-based counseling and referral programs
- **New Jersey Quitnet** – Visit **www.nj.quitnet.com** for personalized support and referrals online

Making medical decisions before your procedure

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

There are three types of advance directives:

- Durable power of attorney – 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.

Learn about our quality management programs

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

We protect your privacy

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

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

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

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

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

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

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

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

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

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

Anyone can get health care

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

We must comply with these laws:

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

How we use information about your race, ethnicity and the language you speak

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

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

When you lose your other coverage

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

When you have a new dependent

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

- Marriage
- Birth
- Adoption
- Placement for adoption

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

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

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

1. **Health Insurance Plans** – for HMO and PPO health plans and
2. **Physicians and Physician Practices** – for physicians recognized by NCQA in the areas of Physician Practice Connections, Physician Practice Connections-Patient Centered Medical Home, Patient Centered Medical Home, Heart/Stroke, Diabetes, and Patient Center Specialty Practice. Providers, in all settings, achieve recognition by submitting data that demonstrate they are providing quality care. The program constantly assesses key measures that were carefully defined and tested for their relationship to improved care; therefore, NCQA provider recognition is subject to change.

See "Other Reports on Health Care Quality" in the 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 1-800-982-3862.

www.aetna.com

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