

# Important disclosure information

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## Understanding your plan of benefits

This disclosure booklet contains important information you should know before you enroll. It is only a summary. Your official plan documents list all the details for the plan you choose. Such as, what's covered, what's not covered and the specific amounts that you will pay for services. Plan documents include a Schedule of Benefits and Policy and updates that come with them.

If you can't find your plan documents, call us at the toll-free number on your digital member ID card.

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.

## Get plan information online and by phone

### If you're already enrolled in an Aetna health plan

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

#### (1) Log in to your secure 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 **aetna.com** and click "Log In." Follow the prompts to complete the one-time registration.

Then you can log in anytime to:

- Access your digital member ID card
- 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 provider 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) Call the toll-free number on your digital member ID card

You can speak with a representative to:

- Understand how your plan works or what you will pay
- Get information about how to file a claim
- Find care outside your area
- File a complaint or appeal
- Get copies of your plan documents
- Connect to behavioral health services
- Find specific health information
- Learn more about our quality management programs

## Not yet a member?

You can call us at **1-888-982-3862** for help understanding how a particular medical plan works.

## Search your plan for doctors, hospitals and other health care providers

Use the online provider search tool for the most up-to-date list of health care professionals, facilities, and network pharmacies. 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 **aetna.com** and log in. From your secure member website home page, select "Find Care" from the top menu bar and start your search.

### Considering enrollment:

Visit **aetna.com** and select "Find a doctor" on the top of the home page. Then follow the steps under "Not a member yet?" to search for providers.

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

## Find out if a doctor is accepting new patients

Provider listings show which doctors are in the network. Some doctors may not accept new patients from time to time. To find out if a doctor is accepting new patients, you can call the doctor's office directly. Or you can call the toll-free phone number on your digital member ID card.

## If your doctor is not in the network or later leaves the network

Our Transition of Care program can give you extra time to finish an active course of treatment or to find a new doctor. It's for new members whose doctor is not in the network. It's also for members whose doctor leaves the network for reasons other than medical incompetence or unprofessional conduct. To qualify, you or your covered dependent must be:

- In an active course of treatment for a life-threatening condition — you may be able to see your doctor for an additional 30 days

## 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.

- In the third trimester of pregnancy — you may be able to see your current doctor for up to 6 weeks after the delivery for care that is related to the delivery

## Get a FREE printed directory

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

We will authorize the coverage for the transitional period only if your doctor agrees in writing:

- To accept our normal reimbursement rates for similar services
- To adhere to our quality standards and to provide medical information related to such care
- To adhere to our policies and procedures

This provision only applies to benefits that are covered under the HMO plan as outlined in the Policy.

**To request Transition of Care, contact us at the number on your digital member ID card.**

## What you pay

### Your share of the cost of health care services

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 receive 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.
- **Deductible — Some plans include a deductible.** This is the amount you owe for health care services before your health plan begins to pay. For example, if your deductible is \$1,000, your plan won't pay anything until you have paid \$1,000 for any covered health care services that are subject to the deductible. The deductible may not apply to all services.

#### Other deductibles may apply at the same time:

- **Inpatient hospital deductible** — 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.

### Going in network just makes sense

We have negotiated discounted rates for you.

In-network doctors and hospitals won't bill you for costs above our rates for covered services.

You are in great hands with access to quality care from our national network.

To learn more about how we pay out-of-network benefits, visit [aetna.com](https://www.aetna.com). Type "how Aetna pays" in the search box.

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.

You may choose a doctor in our network or you may also choose to visit an out-of-network doctor. We cover the cost of care based on your choices.

### Your costs when you go outside the network

- Not every hospital, health care facility, physician or other types of providers participate in the network.
- **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 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.

- 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.
- To learn more about how we pay out-of-network benefits, visit [aetna.com](https://www.aetna.com). Type “how Aetna pays” in the search box.

### **How we pay health care providers based on certain goals\***

Our provider compensation programs do not require providers to comply with any specified numbers, targeted averages, or maximum durations of patient visits.

## **Precertification: Getting approvals for services**

Sometimes we will pay for care only if we have given an approval before you get it. We call that precertification. Precertification is usually limited to more serious care like surgery or being admitted to a nursing home.

Your Network doctor will call us for precertification when that’s required. Your plan documents list all the services that require you to get precertification.

Precertification is not required for emergency services.

### **What we look for when reviewing a precertification request**

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

\*The specific goals will vary from network to network.

### **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.

**Notice:** You must personally bear all costs if you use health care not authorized by this plan or purchase drugs that are not authorized by this plan.

We will not retroactively deny covered nonemergency treatment that had prior authorization under our written policies.

### **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.

### **If you have a chronic condition or an upcoming hospital stay**

You may qualify for one of our case management programs. An Aetna nurse can be the extra support you need. After you enroll, just call the number on your ID card to learn more.

### **Women have direct access to their Ob/Gyn**

Any female member 13 years or older may visit any participating gynecologist for a routine well-woman exam, including a Pap smear when appropriate and an unlimited number of visits for gynecologic problems and follow-up care.

# Information about specific benefits

## What's covered

Eligible health services under the policy include:

- **Preventive care and wellness, including:** Routine physical exams, preventive care immunizations, well-woman preventive visits, preventive screening and counseling services, routine cancer screenings, prenatal care, comprehensive lactation support and counseling services, breast feeding durable medical equipment, and family planning services — female contraceptives
- **Physicians and other health professionals, including:** Physician services, physician surgical services and walk-in clinics
- **Hospital and other facility care,** such as outpatient surgery, home health care and skilled behavioral health services in the home, hospice care, outpatient and inpatient skilled nursing care and skilled nursing facilities
- **Emergency services and urgent care**
- **Pediatric dental care**
- **Specific conditions,** such as autism spectrum disorder, diabetic equipment, supplies and education, other family planning services, jaw joint disorder treatment, maternity and related newborn care, mental health treatment, substance related disorders treatment, reconstructive surgery and supplies, transplant services, and treatment of basic infertility
- **Specific therapies and tests,** such as diagnostic testing, diagnostic complex imaging services, outpatient diagnostic lab work and radiological services, chemotherapy, outpatient infusion therapy, specialty care prescription drugs, outpatient radiation therapy, short-term cardiac and pulmonary rehabilitation services, short-term rehabilitation services, and habilitation therapy services

- **Other services,** like accidental dental services, acupuncture benefit, administration of blood and blood products, ambulance service, clinical trial therapies (experimental or investigational only when you have cancer or a terminal illness and certain conditions are met), clinical trials (routine patient costs), durable medical equipment (DME), hearing aids and exams, nutritional supplements including medical foods to treat inherited metabolic disorders and formulas to treat eosinophilic gastrointestinal disorders, bariatric surgery, orthotic devices, prosthetic devices, pediatric vision care
- **Medications, including:** outpatient prescription drugs, including outpatient prescription contraceptive drugs and devices, preventive care drugs and supplements and risk reducing breast cancer prescription drugs, tobacco cessation prescription and over-the-counter drugs

## Exclusions

**Acupuncture, acupressure and acupuncture therapy,** except where described in the *Eligible health services under your policy* section of your policy.

### Ambulance services

- Ambulance services, for routine transportation to receive outpatient or inpatient services.
- Non-emergency fixed-wing air ambulance transportation from an out-of-network provider.

### Autism spectrum disorder

Early intensive behavioral interventions (including Denver, LEAP, TEACCH, Rutgers, floor time, Lovaas and similar programs) and other intensive educational interventions.

### Artificial organs

Any device that would perform the function of a body organ.

### Blood-related services

Examples of these are:

- The provision of blood to the hospital, other than blood derived clotting factors
- The services of blood donors, apheresis or plasmapheresis

For autologous blood donations, only administration and processing expenses are covered.



**Clinical trial therapies (experimental or investigational)**, except where described in the *Eligible health services under your policy – Clinical trial therapies (experimental or investigational)* section of your policy.

**Clinical trial therapies (routine patient costs)**

- Services and supplies related to data collection and record-keeping that are solely needed due to the clinical trial (that is, protocol-induced costs).
- Services and supplies provided by the trial sponsor without charge to you.
- The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials in accordance with our claim policies).

**Cosmetic services and plastic surgery**

Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body.

**Counseling**

Marriage, religious, family, career, social adjustment, pastoral or financial counseling.

**Court-ordered services and supplies** Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or because of any legal proceeding.

**Custodial care**

Examples are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed.
- Administering oral medications.
- Care of a stable tracheostomy (including intermittent suctioning).
- Care of a stable colostomy/ileostomy.
- Care of stable gastrostomy/ jejunostomy/nasogastric tube (intermittent or continuous) feedings.
- Care of a bladder catheter (including emptying/changing containers and clamping tubing).
- Watching or protecting you.
- Respite care, adult (or child) day care, or convalescent care.
- Institutional care. This includes room and board for rest cures, adult day care and convalescent care.

- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods.
- Any other services that a person without medical or paramedical training could be trained to perform.
- Any service that can be performed by a person without any medical or paramedical training.

**Durable medical equipment (DME)**

Your policy generally covers the same type of DME that Medicare covers. But there are some DME items Medicare covers that your policy does not. These coverage exceptions are any supplies or equipment for comfort, convenience or luxury, including:

- Whirlpools
- Portable whirlpool pumps
- Massage table
- Sauna baths
- Message devices (personal voice recorder)
- Over bed tables
- Elevators
- Communication aids
- Vision aids
- Telephone alert systems

**Dental care for adults**

Dental services related to:

- The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
- Dental services related to the gums
- Apicoectomy (dental root resection)
- Orthodontics
- Root canal treatment
- Soft tissue impactions
- Bony impacted teeth
- Alveolectomy
- Augmentation and vestibuloplasty treatment of periodontal disease
- False teeth
- Prosthetic restoration of dental implants
- Dental implants

This exclusion does not include bone fractures, removal of tumors, and odontogenic cysts.

## **Educational services**

Examples of those services are:

- Any service or supply for education, training or retraining services or testing. This includes special education, remedial education, job training and job hardening programs.
- Evaluation or treatment of learning disabilities, attention deficit disorder, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) or training, regardless of the main cause.
- Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.
- Services such as speech therapy eligible under the Individuals with Disabilities in Education Act (IDEA).

## **Emergency services and urgent care**

- Non-emergency care in a hospital emergency room facility
- Non-urgent care in an urgent care facility or at a non-hospital freestanding facility

## **Examinations**

- Any health or dental examinations needed:
- Because a third party requires the exam. Examples are, examinations to get or keep a job, or examinations required under a labor agreement or other contract.
- Because a court order requires it.
- To buy insurance or to get or keep a license.
- To travel.
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity.

## **Experimental or investigational**

Experimental or investigational drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies (experimental or investigational) or covered under clinical trials (routine patient costs). See the *Eligible health services under your policy – Other services* section.

## **Facility charges**

For care, services or supplies provided in:

- Rest homes
- Assisted living facilities

- Similar institutions serving as a person's main residence or providing mainly custodial or rest care
- Health resorts
- Spas
- Infirmaries at schools, colleges, or camps

## **Family planning services — female contraceptives counseling, devices and voluntary sterilization**

Examples of services and supplies that are not covered under the preventive care and wellness benefit include:

- Over-the-counter (OTC) contraceptive supplies, such as male and female condoms, spermicides and sponges
- OTC emergency contraceptives
- Any contraceptive methods that are only reviewed by the FDA and not approved by the FDA
- FDA approved female brand-name and biosimilar emergency contraceptives
- Contraception services during a stay in a hospital or other facility for medical care
- The reversal of voluntary sterilization procedures, including any related follow-up care

## **Family planning services — other**

- Reversal of voluntary sterilization procedures including related follow-up care
- Services and supplies provided for an abortion (voluntary termination of pregnancy)
- Charges incurred for family planning services while confined as an inpatient in a hospital or other facility

## **Foot care**

Services and supplies for:

- The treatment of calluses, bunions, toenails, hammertoes, fallen arches
- The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
- Supplies (including orthopedic shoes), arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies (except for devices and supplies related to diabetes)

## **Growth/height care**

Except as covered under the *Eligible health services under your plan – Growth hormone therapy* section of the policy:



- A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth
- Surgical procedures, devices and growth hormones to stimulate growth

### **Hearing aids and exams**

The following services or supplies:

- A replacement of a hearing aid installed within the prior 12-month period
- Charges for more than one hearing aid per ear, per year
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist
- Any hearing aid furnished or ordered because of a hearing exam that was done before the date you became covered under this policy
- Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay
- Any tests, appliances and devices to:
  - Improve your hearing. This includes hearing aid batteries and auxiliary equipment.
  - Enhance other forms of communication to make up for hearing loss or devices that simulate speech.

### **Home health care**

- Services for infusion therapy (Coverage is provided as noted in the *Outpatient infusion therapy* section of your policy for more information.)
- Services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present
- Services are not for applied behavior analysis

### **Hospice care**

- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling. This includes estate planning and the drafting of a will.
- Homemaker or caretaker services. These are services which are not solely related to your care and may include:
  - Sitter or companion services for either you or other family members
  - Transportation
  - Maintenance of the house

### **Maintenance care**

Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services.

### **Medical supplies — outpatient disposable**

Any outpatient disposable supply or device. Examples of these are:

- Sheaths
- Bags
- Elastic garments
- Support hose
- Bandages
- Bedpans
- Syringes, except diabetic supplies listed as covered benefits in the Policy
- Blood or urine testing supplies, except diabetic supplies listed as covered benefits in the Policy
- Other home test kits
- Splints
- Neck braces
- Compresses
- Other devices not intended for reuse by another patient

## **Mental health treatment**

- Mental health services for the following categories (or equivalent terms as listed in the most recent version of the International Classification of Diseases [ICD]):
  - Stay in a facility for treatment for dementia and amnesia without a behavioral disturbance that necessitates mental health treatment
  - Sexual deviations and disorders except for gender identity disorders
  - Tobacco use disorders
  - Pathological gambling, kleptomania, pyromania
  - School and/or education service, including special education, remedial education, wilderness programs or any such related or similar programs
- Services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Services are not for applied behavior analysis

## **Nutritional supplements**

Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered in the *Eligible health services under your policy – Other services* section of your policy.

## **Obesity (bariatric) surgery**

Weight management treatment or drug intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, except as covered in the *Eligible health services under your policy – Other services* section and the *Preventive care and wellness – Preventive screening and counseling services* section for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:

- Liposuction, open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy, and open adjustable gastric banding
- Medical treatments, weight control/ loss programs primarily intended to treat, or are related to the treatment of obesity, including morbid obesity

- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
- Hypnosis, or other forms of therapy
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement
- Open vertical banded gastroplasty
- Laparoscopic vertical banded gastroplasty
- Open sleeve gastrectomy
- Laparoscopic sleeve gastrectomy
- Open adjustable

## **Other primary payer**

Payment for a portion of the charge that Medicare or another party is responsible for as the primary payer.

## **Outpatient prescription drugs**

- Abortion drugs
- Allergy serum and extracts
- Any services related to the dispensing, injection or application of a drug
- Biological liquids and fluids
- Brand-name prescription drugs and devices when a generic prescription drug equivalent, biosimilar prescription drug or generic prescription drug alternative is available, unless otherwise covered by medical exception
- Cosmetic drugs
- Cosmetic drugs, medications or preparations used for cosmetic purposes
- Compound prescriptions containing bulk chemicals that have not been approved by the U.S. Food and Drug Administration (FDA)
- Devices, products and appliances that do not have a National Drug Code (NDC)
- Dietary supplements including medical foods

- Drugs or medications:
  - Administered or entirely consumed at the time and place it is prescribed or dispensed
  - Which do not, by federal or state law, require a prescription order (i.e. over-the-counter (OTC) drugs), even if a prescription is written, except where stated in the *Eligible health services under your policy – Outpatient prescription drugs* section
  - That includes the same active ingredient or a modified version of an active ingredient
  - That is therapeutically equivalent or a therapeutic alternative to a covered prescription drug unless a medical exception is approved
  - That is therapeutically equivalent or a therapeutic alternative to an over-the-counter (OTC) product unless a medical exception is approved
  - Provided by, or while the person is an inpatient in, any health care facility, or for any drugs provided on an outpatient basis in any such institution to the extent benefits are payable for it
  - Recently approved by the FDA, but which have not yet been reviewed by our Pharmacy and Therapeutics Committee
  - That includes vitamins and minerals
  - For which the cost is recoverable under any federal, state, or government agency or any medication for which there is no charge made to the recipient
  - That are used for the treatment of sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
  - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our precertification and clinical policies
  - Not approved by the FDA or not proven to be safe and effective
- Duplicative drug therapy (e.g. two antihistamine drugs)
- Genetic care — Any treatment, device, drug, service or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects
- Immunizations related to travel or work
- Immunization or immunological agents
- Implantable drugs and associated devices except where stated in the *Eligible health services under your policy – Preventive care and wellness* and *Outpatient prescription drugs* sections
- Infertility — Injectable prescription drugs used primarily for the treatment of infertility except where stated in the *Eligible health services under your policy – Treatment of infertility* section
- Injectables:
  - Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by us
  - Injectable drugs dispensed by out-of-network pharmacies
  - Needles and syringes, including but not limited to diabetic needles and syringes, except where stated in the *Eligible health services under your policy – Diabetic equipment, supplies and education* section
  - Injectable drugs, unless dispensed through the network specialty pharmacy
  - For any refill of a designated specialty prescription drug not dispensed by or obtained through the network specialty pharmacy
- An updated copy of the list of specialty prescription drugs designated by this policy to be refilled by or obtained through the network specialty pharmacy is available upon request or may be accessed by logging in to your secure member website at **aetna.com**.
- Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps

- Prescription drugs:
    - Dispensed by other than a network retail, home delivery and specialty pharmacies
    - Dispensed by an out-of-network mail-order pharmacy, except in a medical emergency or urgent care situation
    - For which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a prescription is written
    - Filled prior to the effective date or after the end date of coverage under this policy
    - Dispensed by a mail-order pharmacy that includes prescription drugs that cannot be shipped by mail due to state or federal laws or regulations, or when the policy considers shipment through the mail to be unsafe; examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants
    - That include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and is no clinically superior to that drug as determined by the policy
    - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth, or prescription drugs for the treatment of a dental condition unless dental benefits are provided under the policy
    - That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the Aetna Pharmacy Drug Guide (formulary)
    - That are nonpreferred drugs, unless nonpreferred drugs are specifically covered as described in your schedule of benefits. However, a nonpreferred drug will be covered if in the judgment of the prescriber there is no equivalent prescription drug on the Aetna Pharmacy Drug Guide (formulary) or the product on the Aetna Pharmacy Drug Guide (formulary) is ineffective in treating your disease or condition or has caused or is likely to cause an adverse reaction or harm you
      - That are not covered or related to a non-covered service
      - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not medically necessary, or otherwise improper and drugs obtained for use by anyone other than the member identified on the ID card
- We reserve the right to include only one manufacturer's product on the Aetna Pharmacy Drug Guide (formulary) when the same or similar drug (that is, a drug with the same active ingredient), supply or equipment is made by two or more different manufacturers.
- We reserve the right to include only one dosage or form of a drug on the Aetna Pharmacy Drug Guide (formulary) when the same drug (that is, a drug with the same active ingredient) is available in different dosages or forms from the same or different manufacturers. The product in the dosage or form that is listed on our pharmacy drug guide will be covered at the applicable copayment or coinsurance.
- Progesterone — Progesterone for the treatment of premenstrual syndrome (PMS) and compounded natural hormone therapy replacement
  - Prophylactic drugs for travel
  - Refills — Refills dispensed more than one year from the date the latest prescription order was written, or as otherwise permitted by applicable law of the area in which the drug is dispensed
  - Replacement of lost or stolen prescriptions
  - Tobacco use — Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). See the *Eligible health services under the policy – Outpatient prescription drugs* section.
  - Test agents except diabetic test agents

## Outpatient surgery

- The services of any other physician who helps the operating physician.
- A stay in a hospital. (A hospital stay is an inpatient hospital benefit. See the *Eligible health services under your policy – Hospital and other facility care* section.)
- A separate facility charge for surgery performed in a physician's office.
- Services of another physician for the administration of a local anesthetic.

## Pediatric dental care

In addition to the exclusions that apply to health coverage:

- Any instruction for diet, plaque control and oral hygiene
- Cosmetic services and supplies including:
  - Plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance
  - Augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons, except to the extent coverage is specifically provided in the *Eligible health services under your policy* section of your policy
  - Facings on molar crowns and pontics will always be considered cosmetic
- Crown, inlays, onlays, and veneers unless:
  - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material, or
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants and braces (that are determined not to be medically necessary), mouth guards and other devices to protect, replace or reposition teeth
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - For splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Eligible health services under your policy – Specific conditions* section of your policy
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another eligible health service
- Orthodontic treatment except as covered in the *Eligible health services under your policy – Pediatric dental care* section
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication or analgesia (nitrous oxide)
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Routine dental exams and other preventive services and supplies, except as specifically described in the *Eligible health services under your policy – Pediatric dental care* section of your policy
- Services and supplies:
  - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
  - Provided for your personal comfort or convenience or the convenience of another person, including a provider
  - Provided in connection with treatment or care that is not covered under your policy
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a dental provider

**Personal care, comfort or convenience items**

Any service or supply primarily for your convenience and personal comfort or that of a third party.

**Physician surgical services**

- The services of any other physician who helps the operating physician.
- A stay in a hospital (See the *Eligible health services under your policy – Hospital and other facility care* section.)
- A separate facility charge for surgery performed in a physician's office.
- Services of another physician for the administration of a local anesthetic.

**Private duty nursing** (See home health care in the *Eligible health services under your policy – Skilled nursing care* section of your policy regarding coverage of nursing services.)

**Prosthetic devices**

- Services covered under any other benefit
- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

**Services, supplies and drugs received outside of the United States**

Non-emergency medical services, outpatient prescription drugs or supplies received outside of the United States. They are not covered even if they are covered in the United States under the policy.

**Sexual dysfunction and enhancement**

Any treatment, prescription drug, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- Surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
- Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

**Short-term rehabilitation services** Outpatient cognitive rehabilitation, physical, occupational and speech therapy.

- Exceptions include:
  - Physical therapy if it is expected to improve or restore physical functions lost as a result of an acute illness, injury or surgical procedure
  - Occupational therapy (not including vocational rehabilitation or employment counseling) if it is expected to:
    - Improve, develop or restore physical functions you lost as a result of an acute illness, injury or surgical procedure
    - Relearn skills so you can significantly regain your ability to perform the activities of daily living on your own
  - Speech therapy if it is expected to:
    - Improve or restore the speech function or correct a speech impairment as a result of an acute illness, injury or surgical procedure
    - Improve delays in speech function development caused by a gross anatomical defect present at birth
- Examples of non-covered diagnoses or services are:
  - Any service unless provided in accordance with a specific treatment plan
  - Services not given by a physician's office or an outpatient facility

**Specialty prescription drugs**

Eligible health services include specialty prescription drugs when they are:

- Purchased by your provider
- Injected or infused by your provider in an outpatient setting such as:
  - A free-standing outpatient facility
  - The outpatient department of a hospital
  - A physician in his/her office
  - A home care provider in your home
- Listed on our specialty prescription drug list as covered under this policy



### **Strength and performance**

Services, devices and supplies such as drugs or preparations designed primarily to enhance your strength, physical condition, endurance, or physical performance.

### **Substance related disorders treatment**

Alcoholism or drug abuse rehabilitation treatment on an inpatient or outpatient basis, except where described in the *Eligible health services under your policy – Substance related disorders treatment* section of your policy.

### **Telemedicine**

- Any services that are given by providers that are not contracted with Aetna as telemedicine providers.
- Any services that are not provided during an internet-based consult or via telephone.

### **Therapies and tests**

- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used as a physical therapy modality
- Sensory or auditory integration therapy

### **Tobacco cessation**

Except where described in the policy, any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). This also includes:

- Counseling, except where stated in the *Eligible health services under your policy – Preventive care and wellness* section
- Hypnosis and other therapies
- Medications, except where stated in the *Eligible health services under your policy – Outpatient prescription drugs* section
- Nicotine patches
- Gum

### **Transplant services**

- Services and supplies furnished to a donor when the recipient is not a covered person
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness
- Outpatient drugs including bio-medicals and immunosuppressant not expressly related to an outpatient transplant occurrence
- Home infusion therapy
- Harvesting and/or storage of bone marrow, or hematopoietic stem cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness

### **Treatment in a federal, state, or governmental entity**

Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.

### **Treatment of infertility**

All charges associated with the treatment of infertility, except as described under the *Eligible health services under your policy – Treatment of infertility – Basic infertility* section of the policy. This includes:

- All charges associated with:
  - Surrogacy for you or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father.
  - Cryopreservation of eggs, embryos, or sperm.
  - Storage of eggs, embryos, or sperm.
  - Thawing of cryopreserved eggs, embryos or sperm.
  - The care of the donor in a donor egg cycle. This includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests, and any charges associated with care of the donor required for donor egg retrievals or transfers.
  - The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which she is not genetically related.

- Home ovulation prediction kits or home pregnancy tests.
- Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists.
- The purchase of donor embryos, donor oocytes, or donor sperm.
- Reversal of voluntary sterilizations, including follow-up care.
- Any charges associated with obtaining sperm for ART services.
- Ovulation induction with menotropins, intrauterine insemination and any related services, products or procedures.
- In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intrafallopian transfer (GIFT), Cryopreserved embryo transfers and any related services, products or procedures (such as Intracytoplasmic sperm injection (ICSI) or ovum microsurgery).

## **Vision care**

### **Pediatric vision care**

- Eyeglass frames, nonprescription lenses and nonprescription contact lenses that are for cosmetic purposes

### **Adult vision care**

Routine vision exam provided by an ophthalmologist or optometrist including refraction and glaucoma testing and vision care services and supplies.

### **Vision care services and supplies**

Your policy does not cover vision care services and supplies, except as described in the *Eligible health services under your policy – Other services* section of the policy.

- Special supplies such as nonprescription sunglasses
- Eyeglass frames, nonprescription lenses and nonprescription contact lenses that are for cosmetic purposes
- Special vision procedures, such as orthoptics or vision therapy
- Eye exams during your stay in a hospital or other facility for health care
- Eye exams for contact lenses or their fitting
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames

- Replacement of lenses or frames that are lost or stolen or broken
- Acuity tests
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures
- Services to treat errors of refraction

### **Wilderness treatment programs**

- Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting

### **Work-related illness or injuries**

- Coverage available to you under workers' compensation or under a similar program under local, state or federal law for any illness or injury related to employment or self-employment.
- A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law.
- If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered non-occupational regardless of cause.

### **Financial sanctions exclusions**

If coverage provided under this certificate violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for **eligible health services** if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). You can find out more by visiting <http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx>.

## Emergency and urgent care and care after office hours

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

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

- Call **911** or go to the nearest emergency room. If you have time, call your doctor.
- Tell your doctor 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.

### Emergency care is covered

Sometimes, you don't have a choice about where you go for care, like in an emergency. When you need emergency care, we'll treat it like you got the care in network, even if you received it from an out-of-network provider. Emergency care is subject to your deductible. This means that if you've already met your deductible, there's no charge to you.

Also, we may pay less than what an out-of-network provider charges.

Don't worry, for an emergency situation, you don't have to pay it. So, if the provider bills you for the rest of the cost, just call us at the number on your digital member ID card, and we'll take care of it.

See your plan documents and the "Financial sanctions exclusions" section in this booklet for more information.

### After-hours care — available 24/7

Call your doctor anytime if you have medical questions or concerns. Your doctor should have an answering service if you call after the office closes. You can also go to an urgent care center, which may have limited hours. To find a center near you, log in to **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

When your doctor prescribes you a drug, then it's time to use your pharmacy coverage. Use it well, and it can save you money. Here's how:

## You get best coverage when you use a network pharmacy

There is no coverage when you use an out-of-network pharmacy. The pharmacy network may change from time to time. Your secure member website will have the most up-to-date information.

### Find a network pharmacy near you online

Before you fill a prescription, go to your secure member website. There you can find network pharmacies near you. Browse our directory, or you can look them up just like you would a doctor or hospital. See "Search your plan for doctors, hospitals and other health care providers" in this booklet for more.

You can look up your drugs and know the costs ahead of time on your secure member website. Simply log in. Under "See Coverage & Costs," select "Pharmacy Coverage," then "Estimate drug costs." Enter the name of the drug. You'll find your cost for each drug by pharmacy. You can also compare the cost at a local pharmacy with your cost for home delivery to see how much you can save.

### Some plans encourage generic drugs over brand-name drugs

Many brand-name drugs have generic versions with the same active ingredients. Or there may be a different generic drug that can treat your condition. Generic drugs are as safe and effective as their brand-name versions. For certain drugs, you must get the generic. 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 Pharmacy Drug Guide (formulary). This guide shows which prescription drugs are covered under your plan. It also explains how we choose drugs to be in the guide.

When you get a drug that is not covered under your plan, your share of the cost will usually be more. Check your plan documents to see how much you will pay.

## **Home delivery and specialty drug services are from pharmacies that Aetna owns.**

Aetna Rx Home Delivery® and Aetna Specialty Pharmacy® are included in your network and provide convenient options for filling medicine you take every day or specialty medicines that treat complex conditions.

## **You may have to get approval before some drugs covered**

Sometimes your doctor might recommend a drug that's not covered under your plan. 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 or your doctor can ask for an exception through the precertification process.

## **You may request an exception for some drugs that are not covered**

Your plan documents might list specific drugs that are not covered. Your plan may also not cover drugs that we haven't reviewed yet. You, someone helping you or your doctor may have to get our approval (a medical exception) to use one of these drugs.

## **Find out what drugs your plan covers**

You can find covered drugs on your secure member website. Or, you can call the toll-free number on your digital member ID card to ask for a printed copy of the covered drug list. We may sometimes change the drugs we cover. Look online or call the toll-free number on your digital member ID card for the latest updates.

## **Mental health and addiction benefits**

You must use therapists and other mental health professionals who are in the Aetna network. Here's how to get inpatient and outpatient services, partial hospitalization and other mental health services:

- Call **911** if it's an emergency.
- Use the online provider search tool at [aetna.com](https://www.aetna.com).
- Call the toll-free number on your digital member ID card.

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

- **Beginning Right® Depression Program:** Perinatal and Postpartum screening, Depression Education, Treatment Referral
- **OORS Program:** Opioid Overdose Risk Screening Program

Call Member Services to learn more about these programs.

## **Transplants and other complex conditions**

Our National Medical Excellence Program® is for members who need a transplant or have a condition that can only be treated at a certain hospital. You usually need to use an 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 National Medical Excellence 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**

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Protheses
- Treatment of physical complications of the mastectomy, including lymphedema

Benefits will be provided to a person who has already undergone a mastectomy as a result of breast cancer while covered under a different health plan. 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. For more information, please contact Member Services at the number on your ID card, or the links below.

## Fact sheet from the U.S. Department of Health and Human Services:

[www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra\\_factsheet.html](http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet.html)

## Pamphlet from the U.S. Department of Labor:

<https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/your-rights-after-a-mastectomy.pdf>

## How we determine 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 the toll-free number on your digital member ID card 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 condition, or to check if you have one. It might also be to treat an injury or illness.

The product or service:

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

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

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

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

Doctors can write or call our Patient Management department with questions. Contact us either online or at the phone number on your digital member ID card for the appropriate address and phone number.

### We study the latest medical technology

To help us decide what is medically necessary, we may look at scientific evidence published in medical journals. This is the same information doctors use. We also make sure the product or service is in line with how doctors, who usually treat the illness or injury, use it. Our doctors may use nationally recognized resources like MCG (formerly Milliman Care Guidelines). We also review the latest medical technology, including drugs, equipment — even mental health treatments. Plus, we look at new ways to use old technologies.

To make decisions, we may:

- Read medical journals to see the research. We want to know how safe and effective it is.
- See what other medical and government groups say about it. That includes the federal Agency for 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 [aetna.com](http://aetna.com)

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

CPBs 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 [aetna.com](http://aetna.com). You can find them under "Providers." 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.



## How we determine whether to pay a claim

A claim occurs whenever you, your doctor or your authorized representative requests one of the following:

- Precertification for a service that requires prior approval
- Payment for services or treatment received

As an Aetna member, you do not have to submit claims for in-network services. Your doctors will do that for you. However, if you receive a bill for covered benefits, please send it to us for payment. Clearly mark your Aetna member ID number on the bill and mail it to the address shown on your digital member ID card. We will make a decision on the claim.

For urgent care claims and preservice claims, we will send you written notification of our determination whether to pay the claim or not. For other types of claims, we may only notify you if we determine not to pay the claim, or if we reduce the claim amount.

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 or is an experimental or investigational procedure.
- A 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 or otherwise excluded from coverage.
- You have reached a plan limitation.
- You or our dependents are not eligible for coverage.

We will notify you in writing within the following time frames. Under certain circumstances, these time frames may be extended. The notice will provide important information that will help you appeal the adverse benefit determination if you wish to do so.

Please see the Arizona Appeals Packet, which accompanies this booklet, for more information about appealing an adverse benefit determination.

## What to do if you disagree with us

### Complaints, appeals and external review

Please tell us if you are not satisfied with a response you received from us or with how we do business.

You can designate a representative to participate in the complaint or grievance process. All disputes involving denial of payment for a health care service will be made by qualified personnel with experience in the same or similar scope of practice.

### Time frames for notifying you that we denied a claim

Type of claim	Aetna response time from receipt of claim
<b>Urgent care claim.</b> A claim for medical care or treatment where 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.
<b>Preservice claim.</b> A claim for a benefit that requires preauthorization of the benefit before you receive the medical care.	Within 15 calendar days.
<b>Concurrent care claim extension.</b> 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.
<b>Concurrent care claim reduction or termination.</b> Decision to reduce or terminate a course of treatment that we previously approved.	With enough advance notice to allow the member to appeal.
<b>Post service claim.</b> A claim for a benefit that is not a preservice claim.	Within 30 calendar days.



Call the toll-free number on your digital member ID card to file a verbal complaint or to ask for the address to mail a written complaint. You can also email us through your secure member website. See “Get plan information online and by phone” for more information.

If you’re not satisfied after talking to a health plan representative, you can ask us to send your issue to the appropriate complaint department.

**If you don’t agree with a decision related to a denied claim, you can file an appeal.**

To file an appeal, follow the directions in the letter or explanation of benefits statement that explains that your claim was denied.

The letter will also include information about the basis for the denial, what we need from you if you wish to appeal the decision, and how soon we will respond to your appeal. The complete process for filing an appeal in Arizona is described in the “Health care insurer appeals process information packet,” which accompanies this document.

**Get a review from someone outside Aetna**

If the denial is based on a medical judgment, you may be able to get an outside review if you’re not satisfied with your appeal (in most cases you will need to finish all of your internal appeals first). Follow the instructions on our response to your appeal. You’ll find the appropriate form in the “Health care insurer appeals process information packet,” which accompanies this document. You can also visit [aetna.com](https://www.aetna.com) and enter external review in the search bar. Or call the toll-free number on your digital member ID card to ask for an External Review Form.

An Independent Review Organization (IRO) will assign your case to one of their experts. The expert will be a doctor or other professional who specializes in that area or type of appeal. You should have a decision within 45 calendar days of the request. The outside reviewer’s decision is final and binding; we will follow the outside reviewer’s decision and you will not have to pay anything unless there was a filing fee.

**A rush review may be possible**

If your doctor thinks you cannot wait 45 days, ask for an expedited review. That means we will make our decision within one day. You’ll find the appropriate form in the “Health care insurer appeals process information packet,” which accompanies this document.

## 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 [aetna.com/individuals-families/member-rights-resources.html](https://www.aetna.com/individuals-families/member-rights-resources.html) to view the list. You can also call the number on your digital member ID card to request a printed copy or for more information.

### Making medical decisions before your procedure

An advance directive tells your family and doctors what to do when you can’t tell them yourself. You don’t need an advance directive to receive care. But you have the right to create one.

Hospitals may ask if you have an advance directive when you are admitted.

There are three types of advance directives:

- Durable power of attorney — names the person you want to make medical decisions for you.
- Living will — spells out the type and extent of care you want to receive.
- Do-not-resuscitate order — states 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.

## 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, including goals and outcomes, go to our website at [aetna.com](https://www.aetna.com). Enter "Quality Management and Improvement Efforts" in the search bar. You can also call Member Services to ask for a printed copy. The toll-free number is on your Aetna 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)

For more information or to request special enrollment, you can call the phone number on your digital member ID card. If you are not a member yet, you can call **1-888-982-3862**.

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 digital member ID card or visit us at [aetna.com](https://www.aetna.com).

\*\*American Academy of Family Physicians. Advance Directives and Do Not Resuscitate Orders. January 2012. Available at: <https://familydoctor.org/advance-directives-and-do-not-resuscitate-orders/>. Accessed May 15, 2018.

## **Anyone can get health care**

We do not consider your race, disability, religion, sex, sexual orientation, gender identity, 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. This includes enrolling your spouse or children and other dependents.

If that happens, you must apply within 31 days before you expect to lose coverage and 31 days after your coverage ends.

### **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 certain life events if you chose not to enroll during the normal open enrollment period.

These life events include:

- Marriage
- Birth
- Adoption
- Placement for adoption

For more information or to request special enrollment, you can call the phone number on your digital member ID card. If you are not a member yet, you can call **1-888-982-3862**.

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 Plans** – for HMO and PPO health plans
2. **Health Care Providers** – 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.
3. **Other Health Care Organizations** –
  - **Filter your search by “Managed Behavioral Healthcare Organizations”** – for behavior health accreditation
  - **Filter your search by “Credentials”** – 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.**

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call **1-888-982-3862**.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

**1-800-648-7817**, TTY: **711**,

Fax: **859-425-3379** (CA HMO customers: **860-262-7705**), [CRCoordinator@aetna.com](mailto:CRCoordinator@aetna.com).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at **1-800-368-1019**, **800-537-7697** (TDD).



