

Important disclosure information

Aetna Health Maintenance Organization (HMO) plans

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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 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.

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 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/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 online provider search tool to find 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 your secure member website

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)

* Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. Health benefits plans are offered by Aetna Health Inc.

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.

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

Use our online provider 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 [aetna.com](https://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 [aetna.com](https://www.aetna.com) and select "Find a doctor" on 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

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.

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.

Other copays may apply at the same time:

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

- **Deductible** – The amount you owe for health care services before your health plan begins to pay. For example, if your deductible is \$1,000, you have to pay the first \$1,000 for covered services before the plan begins to pay. You may not have to pay for some services.

Your costs when you go outside the network

HMOs are network-only plans. That means the plan covers health care services only when provided by a doctor who participates in the Aetna network. If you receive services from an out-of-network doctor or other health care provider, you will have to pay all of the costs for the services. See “Emergency and urgent care and care after office hours” for more.

Going in network just makes sense

- We have negotiated discounted rates for you.
- 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.

How we pay providers

Our compensation to physicians who offer health care services to our insured members or enrollees may be based on a variety of payment mechanisms such as fee-for-service payments, case rate, or capitation. Bonuses may be used with these various types of payment methods.

If you desire additional information about our methods of paying physicians, or if you want to know which method(s) apply to your physician, please call us at 1-888-982-3862.

Terms	The example shows how Dr. Jones, an obstetrician gynecologist, would be compensated under each method of payment.	Percentage of physicians paid using this described method
Salary	<p>A physician is an employee of Aetna and is paid compensation (monetary wages) for providing specific health care services. Since Dr. Jones is an employee of Aetna, she receives her usual biweekly salary regardless of how many patients she sees or the number of services she provides. During the months of providing prenatal care to Mrs. Smith, who is a member of Aetna, Dr. Jones' salary is unchanged. Although Mrs. Smith's baby is delivered by Cesarean section, a more complicated procedure than a vaginal delivery, the method of delivery will not have any effect upon Dr. Jones' salary.</p>	0%
Capitation	<p>A physician (or group of physicians) is paid a fixed amount of money per month by Aetna for each patient who chooses the physician(s) to be his or her doctor. Payment is fixed without regard to the volume of services an individual patient requires.</p> <p>Under this type of contractual arrangement, Dr. Jones participates in an Aetna network. She is not employed by Aetna. Her contract with Aetna stipulates that she is paid a certain amount each month for patients who select her as their doctor. Since Mrs. Smith is a member of Aetna, Dr. Jones' monthly payment does not change as a result of her providing ongoing care to Mrs. Smith. The capitation amount paid to Dr. Jones is the same whether or not Mrs. Smith requires obstetric services.</p>	5.59%
Fee-for-Service	<p>A physician charges a fee for each patient visit, medical procedure or medical service provided. Dr. Jones' contract with the insurer or Aetna states that Dr. Jones will be paid a fee for each patient visit and each service she provides. The amount of payment Dr. Jones receives will depend upon the number, types, and complexity of services, and the time she spends providing services to Mrs. Smith. Because Cesarean deliveries are more complicated than vaginal deliveries, Dr. Jones is paid more to deliver Mrs. Smith's baby than she would be paid for a vaginal delivery. Mrs. Smith may be responsible for paying some portion of Dr. Jones' bill.</p>	98%

Terms	The example shows how Dr. Jones, an obstetrician gynecologist, would be compensated under each method of payment.	Percentage of physicians paid using this described method
Discounted Fee-for-Service	<p>Payment is less than the rate usually received by the physician for each patient visit, medical procedure, or service. This arrangement is the result of an agreement between the payer, who gets lower costs and the physician, who usually gets an increased volume of patients.</p> <p>Like fee-for-service, this type of contractual arrangement involves Aetna paying Dr. Jones for each patient visit and each delivery; but, under this arrangement, the rate, agreed upon in advance, is less than Dr. Jones' usual fee. Dr. Jones expects that in exchange for agreeing to accept a reduced rate, she will serve a certain number of patients. For each procedure she performs, Aetna will pay Dr. Jones a discounted rate.</p>	0%
Bonus	<p>A physician is paid an additional amount over what he or she is paid under salary, capitation, fee-for-service or other type of payment arrangement. Bonuses may be based on many factors, including member satisfaction, quality of care, control of costs and use of services.</p> <p>Aetna rewards its physician staff or contracted physicians who have demonstrated higher than average quality and productivity. Because Dr. Jones has delivered so many babies and she has been rated highly by her patients and fellow physicians, Dr. Jones will receive a monetary award in addition to her usual payment.</p>	1%
Case Rate	<p>Aetna and the physician agree in advance that payment will cover a combination of services provided by both the physician and hospital for an episode of care.</p> <p>This type of arrangement stipulates how much Aetna will pay for a patient's obstetric services. All office visits for prenatal and postnatal care, as well as the delivery, and hospital-related charges are covered by one fee. Dr. Jones, the hospital, and other providers (such as an anesthesiologist) will divide payment from Aetna for the care provided to Mrs. Smith.</p>	0%

Rewarding PCPs for quality service

In some plans, we pay our PCPs a flat amount each month for each Aetna member who lists them as their PCP. This is called “capitation.” In some cases, we give them the opportunity to earn more when they provide quality care.

Each year we review these measures:

- Member satisfaction
- Percentage of members who visit them at least once a year
- Medical record reviews
- The burden of illness of the members who have selected the PCP
- Management of chronic illnesses like asthma, diabetes and congestive heart failure
- Whether the doctor accepts new patients
- If they use our electronic claims and referral submission program

After the review, we give them a score. This score determines the flat rate we pay them. We encourage you to ask your doctors and other health care providers how they are paid for their services.

Choose a primary care physician

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

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

A female member may choose an Ob/Gyn as her PCP. You may also choose a pediatrician for your child (ren)’s PCP. Your Ob/Gyn acting as your PCP will provide the same services and follow the same guidelines as any other PCP. He or she will issue referrals to other doctors (if your plan requires referrals). He or she will also get

approvals you may need and comply with any treatment plans you are on. See the sections about referrals and precertification for more information.

Tell us who you chose to be your PCP

Each member of the family may chose a different PCP from the Aetna network. Enter the PCP ID# you have chosen on your enrollment form. Or, call Member Services after you enroll to tell Aetna your selection. You may change your selected PCP at any time.

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

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

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

Remember these points about referrals:

- You do not need a referral for emergency care.
- If you do not get a referral when required, you may have to pay the bill yourself.
- Your specialist might recommend treatment or tests that were not on the original referral. In that case, you may need to get another referral from your PCP for those services.
- Women can go to an Ob/Gyn without a referral. See “PCP and referral rules for Ob/Gyns” for more.
- Referrals are valid for one year as long as you are still a member of the plan. Your first visit must be within 90 days of the referral issue date.
- Network-only plans – You can get a special referral if a network specialist is not available. You are required to get approval from us when you get a referral to an out-of-network specialist.

Referrals within physician groups

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

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

A female member can choose an Ob/Gyn as her PCP. Women can also go to any Ob/Gyn who participates in the Aetna network without a referral or prior authorization.

Visits can be for:

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

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

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.

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.

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 care 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.

We support experimental medical treatment

We support physician requests for experimental treatment for life-threatening illness:

- When there is disease progression after conventional treatment
- When there is no conventional treatment and the proposed treatment is delivered
- Under Institutional Review Board (IRB) supervision
- As part of a clinical trial to advance science

This policy supports all phases of clinical trials, including Phase I studies. Each request for such services is evaluated by the National Medical Excellence Unit.

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

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

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

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

Information about specific benefits

Emergency and urgent care and care after office hours

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

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

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

You are covered for emergency care

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

Sometimes you don't have a choice about where you go for care, like if you go to the emergency room for chest pain after a car accident. When you need emergency 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 network care. You pay your plan's copayments, coinsurance and deductibles for your 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 **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 Pharmacy Drug Guide (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.

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 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.

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 also may 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.

Get a copy of the preferred drug guide

You can find the Aetna Pharmacy Drug Guide (formulary) on our website at [aetna.com/formulary/](https://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 illness, emotional disorders, and drug and/or alcohol abuse benefits

These plans cover mental illness, emotional disorders, and drug and alcohol abuse services as outlined below. Plan requirements and limitations, including the precertification requirements, copayment requirements and benefit limitations set forth below, shall apply only to the same extent and will be administered in the same way as for physical illnesses.

“Alcohol abuse” means a disease that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial or psycho-social.

“Drug abuse” means a disease that is characterized by a pattern of pathological use of a drug with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial or psycho-social.

“Residential crisis services” means intensive mental health and support services that are: provided to a child or an adult with a mental illness who is experiencing or is at risk of a psychiatric crisis that would impair the individual’s ability to function in the community; designed to prevent a psychiatric inpatient admission; an alternative to psychiatric inpatient admission, or expected to shorten the length of an inpatient stay; provided out of the individual’s residence on a short-term basis in a community-based residential setting; and provided by entities that are licensed by the Department of Health and Mental Hygiene to provide residential crisis services.

1. Inpatient benefits

You are covered for inpatient mental illness, emotional disorders, drug and/or alcohol abuse services, including residential crisis services, in a hospital or entity licensed by the Department of Health and Mental Hygiene to provide residential crisis services. Except in an emergency, if your plan requires a PCP referral for benefits related to physical illness, then you must also get a referral for inpatient mental illness, emotional disorders, and drug and/or alcohol abuse services.

Except for any overall annual and lifetime dollar limits that may apply to all benefits, including benefits for physical illnesses, no other maximum limitations will apply to this benefit. The inpatient hospital copayment listed on your Schedule of Benefits applies to this benefit.

2. Partial hospitalization treatment benefits

You are covered for partial hospitalization days for the treatment of mental illness, emotional disorders, and drug and/or alcohol abuse. Except in an emergency, if your plan requires a PCP referral for partial hospitalization benefits related to physical illness, then you must also get a referral for mental illness, emotional disorders, and drug and/or alcohol abuse services.

The maximum number of days, if any, is shown on the Schedule of Benefits. You are responsible for the partial hospitalization days copayment listed on your Schedule of Benefits.

3. Outpatient benefits for mental illness, emotional disorders, and drug or alcohol abuse

You are covered for the treatment of mental illness, emotional disorders, and drug or alcohol abuse outpatient visits to a participating mental health or substance abuse provider. Visits may be for individual, group or family therapy sessions. Coverage includes psychological and neuropsychological testing for diagnostic purposes. Except in an emergency, if your plan requires a PCP referral for benefits related to physical illness, then you must also get a referral for outpatient mental illness, emotional disorders, and drug and/or alcohol abuse services.

The copayment for outpatient visits for mental illness, emotional disorders, drug or alcohol abuse listed on your Schedule of Benefits applies to this benefit. The copayment schedule for this benefit renews each year. Visits to a physician or other health care provider for medication management will not be counted against the number of visits for outpatient services.

The copayment for daily methadone maintenance treatment, if any, is listed on your Schedule of Benefits.

Contact the Maryland Insurance Administration at the following address for more information about these benefits

Maryland Insurance Administration
Attn: Consumer Complaint Investigation
Life and Health/Appeals and Grievance
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

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 [aetna.com/docfind](https://www.aetna.com/docfind) and select the "Quality and Cost Information" link. Then choose "Get info on Patient Safety and Quality." No Internet? Call Member Services instead. Use the toll-free number on your Aetna ID card to ask for a printed copy.

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

- **Beginning Right® Depression Program:** Perinatal and Postpartum Depression Education, Screening and Treatment Referral
- **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® (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

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;
- Prostheses; and
- 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.

Centers for Medicare & Medicaid Services fact sheet

https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet.html

U.S. Department of Labor website

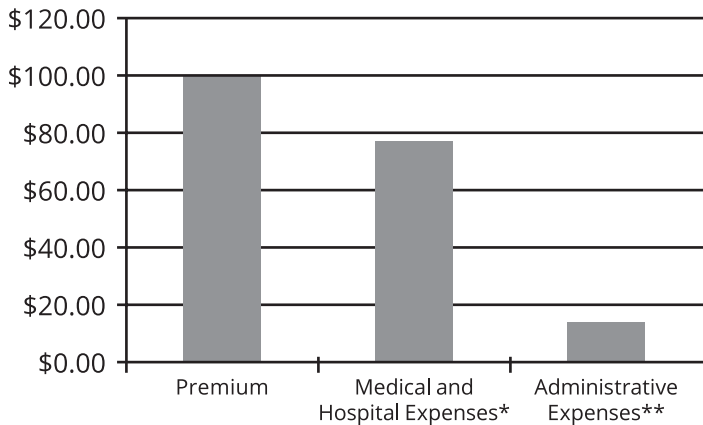
<https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/your-rights-after-a-mastectomy.pdf>

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.

Premium dollar distribution disclosure



The cost of providing health care services in the State of Maryland did not exceed the premium revenue per \$100.

*Medical and Hospital Expenses includes the costs of physician services, other professional services, referrals, emergency room visits, hospitalization and pharmacy.

** Administrative Expenses include, but may not be limited to: occupancy, depreciation and amortization, marketing, salaries, interest expense and accounting and corporate expenses.

Knowing what is covered

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

We check if it's "medically necessary"

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

The product or service:

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

Only medical professionals can decide if a treatment or service is not medically necessary. We do not reward Aetna employees for denying coverage. Sometimes a physicians' 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 physicians' 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 [aetna.com/about/cov_det_policies.html](https://www.aetna.com/about/cov_det_policies.html) to read our policies. Doctors can write or call our Patient Management department with questions. Contact Member Services either online or at the phone number on your Aetna ID card for the appropriate address and phone number.

Avoid unexpected bills.

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

We study the latest medical technology

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

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

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

- Ask experts
- Check how often and how successfully it has been used
We publish our decisions in our Clinical Policy Bulletins.

We post our findings on 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 **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.

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.

Call Member Services to file a verbal complaint or to ask for the appropriate address to mail a written complaint

The phone number is on your Aetna ID card. You can also e-mail Member Services through the secure member website.

If you're not satisfied after talking to a Member Services representative, you can ask that your issue be sent to the appropriate complaint department.

If you don't agree with a denied claim, you can file an appeal

To file an appeal, follow the directions in the letter or explanation of benefits statement that says your claim was denied. The letter also tells you what we need from you and how soon we will respond.

You, or your provider acting on your behalf, may file a complaint with the Commissioner without first filing an appeal. If the coverage decision involves an urgent

medical condition for which care has not been rendered, you can write to:

Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Telephone Number: **1-410-468-2000**
TTY: **1-800-735-2258**
Toll-free: **1-800-492-6116**
Fax: **1-410-468-2270**

The Health Advocacy Unit is available to assist you and/or your provider in both mediating and filing an appeal under the carrier's internal appeals process. You can contact them at:

Health Education and Advocacy Unit Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
Telephone Number: **1-410-528-1840**
Toll-free: **1-877-261-8807**
Fax: **1-410-576-6571**
E-mail: **Heau@oag.state.md.us**

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. Call Member Services to ask for an external review form. You can also visit **aetna.com**. Enter "external review" into the search bar.

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 more quickly.

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 Member Services at the number on your ID card to ask for a printed copy.

Making medical decisions before your procedure

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

There are three types of advance directives:

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

You can create an advance directive in several ways:

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

Source: American Academy of Family Physicians. Advance Directives and Do Not Resuscitate Orders. Available at <https://familydoctor.org/advance-directives-and-do-not-resuscitate-orders/>. Accessed May 4, 2018.

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.

You may request a copy of the Behavioral Health Care Expense Form

As required by Maryland regulation, we must complete and maintain a Behavioral Health Care Expense Form within 90 days after the end of each calendar year. This form is available upon request to an individual, enrollee or member. We may charge a fee up to \$15 plus actual postage and handling.

The Behavioral Health Care Expense Form contains the following information:

- The name of each managed behavioral health care organization with which the carrier has a contract
- The calendar year for which the data are reported
- Total direct payments made by the carrier to each managed behavioral health care organization during the calendar year
- Direct behavioral health care expenses during the calendar year
- Amounts included in direct behavioral health care expenses for quality assurance or utilization management activities or treatment plan reviews
- Behavioral health care administrative expenses during the calendar year
- The name, title, telephone number and signature of the individual completing the form and the date the form was completed

To request a copy of the Behavioral Health Care Expense Form, please call Member Services at the toll-free number on your 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 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.

Special enrollment periods for groups with 1 to 50 employees on the Exchange

Outside of the annual open enrollment period, you, the subscriber, your spouse or child can enroll for coverage within 30 days after the occurrence of one of the following events:

- (1) You, your spouse or child involuntarily loses minimum essential coverage including COBRA or state continuation coverage;
- (2) You, your spouse or child's enrollment or non-enrollment in another health plan was unintentional, inadvertent or erroneous and was the result of the error, misrepresentation or inaction of an officer, employee or agent of a health plan.
- (3) You, your spouse or child adequately demonstrates to us that another health plan in which you were enrolled substantially violated a material provision of its contract;

(4) You, your spouse or child move and become eligible for new health plans.

(5) You gain a dependent or become a dependent through marriage, birth, adoption or placement for adoption or foster care.

We must receive notice and any premium payment within 30 days of one of these events.

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

(6) You, your spouse or child loses eligibility for Medicaid coverage including Medicaid coverage for pregnancy-related services, Medicaid coverage for the medically needy and CHIP but not including other Medicaid programs that do not provide coverage for primary and specialty care.

We must receive notice and any premium payment within 60 days of this event.

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

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

1. **Health Plans** – for HMO and PPO health plans and
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.

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).



TTY: 711

To access language services at no cost to you, call 1-888-982-3862.

Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862. (Spanish)

如欲使用免費語言服務，請致電 1-888-982-3862。 (Chinese)

무료 언어 서비스를 이용하려면 1-888-982-3862번으로 전화해 주십시오. (Korean)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-982-3862. (Vietnamese)

Afin d'accéder aux services langagiers sans frais, composez le 1-888-982-3862. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-982-3862. (Tagalog)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-982-3862. (Russian)

የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-888-982-3862 ይደውሉ። (Amharic)

Iji nwetaòhèrè na orụ gasị asụsụ n'efu, kpọọ 1-888-982-3862. (Ibo)

M̄ d̄yi wuḍu-dù kà kò d̄ò b̄ě d̄yi m̄óuñ n̄i P̄idyì ní, n̄ií, ḍá n̄òbà n̄ià k̄e: 1-888-982-3862. (Kru-Bassa)

Lati wọnú awọn isẹ èdè l'ọfẹ fun ọ, pe 1-888-982-3862. (Yoruba)

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-888-982-3862 پر بات کریں۔ (Urdu)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-888-982-3862 تماس بگیرید. (Persian-Farsi)

Pou jwenn sèvis lang gratis, rele 1-888-982-3862. (French Creole-Haitian)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-982-3862. (Portuguese)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-888-982-3862. (Arabic)

તમારે કોઇ જાતના ખર્ચ વિના ભાષાની સેવાઓની પહોંચ માટે, કોલ કરો 1-888-982-3862. (Gujarati)

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.