

Important disclosure information

Quality Point of Service® (QPOS®)

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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.

If you have questions, please contact us at:

Aetna Health Inc.
1800 East Interstate Avenue
Bismarck, North Dakota 58503
1-888-982-3862

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

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

Where to find information about your specific plan

Your “plan documents” list all the details for the plan you choose. This includes what’s covered, what’s not covered and what you will pay for services. Plan document names vary.

They may include a Booklet-Certificate, Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Group Insurance Policy and/or any riders and updates that come with them.

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

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

Get plan information online and by phone

If you’re already enrolled in an Aetna health plan

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

1. Log in to your secure 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 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)

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 Care" 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

Not every participating health care provider will be accepting new patients. Although we have identified providers who were not accepting patients as known to us at the time their listings in the physician directory and online provider search tool were created, the status of a provider's practice may have changed.

For the most current information, you may contact the provider directly or call Member Services at the toll-free number listed on your ID card.

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**.

Our provider credentialing process

The director of the Department of Insurance, Financial Institutions and Professional Registration develops the standard credentialing form we use when credentialing health care professionals in a managed care plan. If we demonstrate a need for more information, the director of the Department of Insurance, Financial Institutions and Professional Registration may approve a supplement to the standard credentialing form. All forms and supplements meet all requirements as defined by the National Committee of Quality Assurance.

Accountable Care Organizations — Physician networks that help to improve care while lowering costs

Accountable care organizations are networks of primary care doctors, specialists and at least one hospital. Their mission is to better coordinate patient care to improve efficiency, quality and patient satisfaction.

Like most plans, we pay these doctors and hospitals on a fee-for-service basis. We pay them more when they meet certain goals. The amount of these payments depends on how well the networks meet goals* for efficiency and quality:

- Increase screenings for cancer, diabetes and cholesterol
- Reduce avoidable ER visits, short-term hospital stays, repetitive tests and the overall cost of care

The network may also have to make payments to us if they fail to meet their goals. This helps encourage savings that are tied to value and better health outcomes for our members.

Doctors and hospitals that are members of an accountable care network may have their own financial arrangements through the network itself. Ask your doctor for details.

It's important for doctors to see a complete view of your health care to provide customized treatment plans for your unique needs. For that reason, we may share your health information with the accountable care organization and/or doctors within the network.

You can see which health care providers are part of an accountable care organization when you use our online provider search tool. See "Search our network for doctors, hospitals and other health care providers" in this booklet for details. After entering your search criteria, look for the specific network logo.

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.

* The specific goals will vary from network to network.

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.

- **Coinsurance** – Your share of the costs for a covered service. This is usually a percentage (for example, 20 percent) of the allowed amount for the service. For example, if the health plan's allowed amount for an office visit is \$100 and you've met your deductible, your coinsurance payment of 20 percent would be \$20. The health plan pays the rest of the allowed amount.

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

Other deductibles may apply at the same time:

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

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

You are responsible for all coinsurance, copayments and deductibles that apply under your particular plan and may be responsible for premiums depending on the terms of your plan. You are also responsible for the costs of health care services, procedures or treatments that are not covered under the plan. Please refer to your plan documents for a more detailed description of these responsibilities as well as any provisions for annual limits on your financial responsibility and any limits on payments for covered services.

Your costs when you don't get a referral or you go outside the network

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

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

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

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

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

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.

To learn more about how we pay out-of-network benefits, visit aetna.com. Type "how Aetna pays" in the search box.

Choose a primary care physician

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

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

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

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 choose 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 may refer you to a specialist when needed

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

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

Remember these points about referrals:

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

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.

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.

Initial Determinations – For inpatient hospitalizations and ongoing courses of treatment, we will make our initial determination within one working day of receiving a completed request. We will then notify your provider of the decision within 24 hours of making the decision. We will also send written or electronic confirmation of the decision to you (or your designated representative) and your provider within 24 hours of the verbal notification. If the service is certified, we will notify your health care provider by telephone within 24 hours. We will provide written or electronic confirmation to you or your designated representative and your doctor within two working days of the telephone notice.

If there is an adverse determination (such as a denial or reduction of benefit), we will notify your doctor by telephone within 24 hours. Written/electronic confirmation will follow within one working day of the telephone notice.

Concurrent Review – We will review your case while you are confined on an inpatient basis to make sure you received the appropriate level of care.

We must make our determination within one working day of obtaining all necessary information. If the service is certified, we will notify your doctor by telephone within one working day. We will send written/electronic confirmation to you or your designated representative and your doctor within one working day of our telephone notice.

If there is an adverse determination (such as a denial or reduction of benefits), we will notify your doctor by telephone within 24 hours and follow that up with written notice within one working day of our phone call. Your services will continue without liability to you until you have been notified.

Discharge planning – This can be initiated at any stage of the patient management process and begins when we receive your post-discharge needs during precertification or concurrent review. Your discharge plan may include a variety of services or benefits after you leave the facility.

Retrospective Record Review – This review is conducted after you have received services. The purpose is to retrospectively analyze potential quality and utilization issues, initiate appropriate follow-up action based on quality or utilization issues, and review all appeals of inpatient concurrent review decisions for coverage of health care services. Our effort to manage the services provided to you includes the retrospective review of claims submitted for payment, and of medical records.

We will make retrospective review determinations within 30 working days of obtaining all necessary information.

Notice of the determination will be provided to you in writing within 10 days of the determination.

For cases in which you or your provider will not release the necessary information, we may deny the services.

Reconsideration – For initial and concurrent review of services, we will give your doctor an opportunity to request, on your behalf, a reconsideration of an adverse determination by the individual making the determination. Reconsideration will occur within one working day of receipt of the request. It is conducted between the doctor and reviewer, or a clinical peer designated by the reviewer if the reviewer is not available. If this reconsideration does not resolve the issue, you, your designated representative or your provider on your behalf may appeal the adverse determination.

Reconsideration is not a prerequisite to an appeal.

How you or your doctor may contact us

- Call the number on your Aetna ID card to request precertification.
- We prefer electronic submission for precertification requests and inquiries. Your doctor may call our Provider Service Center at **1-800-624-0756** to confirm benefits and eligibility.
- For information about Clinical Policy Bulletins or our online provider search tool directory, please see your plan documents or refer to those topics in this disclosure document.

- Contact Aetna Pharmacy Management at **1-800-414-2386** for precertification of oral medications only.
- Contact Aetna Specialty Pharmacy at **1-866-782-2779** for information on injectable medications.
- Precertification approvals are valid for six months.

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 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](https://www.aetna.com) and search our list of doctors and other health care providers. Check your plan documents to see how much you must pay for urgent care services.

Prescription drug benefit

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

Some plans encourage generic drugs over brand-name drugs

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

We may also encourage you to use certain drugs

Some plans encourage you to buy certain prescription drugs over others. The plan may even pay a larger share for those drugs. We list those drugs in the Aetna 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, and 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/. You can call the toll-free number on your Aetna ID card to ask for a printed copy. We are constantly adding new drugs to the guide. Look online or call Member Services for the latest updates.

Have questions? Get answers.

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

Mental health and addiction benefits

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

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

Get information about using network therapists

We want you to feel good about using the Aetna network for mental health services. Visit 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;
- Prosthesis; 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

http://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.

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 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

You have the right to designate a representative to help you with the complaint, appeal or external review process.

Contact Member Services to file a verbal complaint or to ask for the address to mail a written grievance.

Please tell us if you are not satisfied or disagree with a response you received from us or with how we do business. You have the right to file a formal complaint (grievance) when a dispute is about referrals or covered benefits.

You can:

- Log in at **aetna.com** to e-mail Member Services through the secure member website;
- Use the phone number on your Aetna ID card; or

- If you don't have your ID card, call **1-877-872-3862** and a switchboard operator will connect you to the appropriate Member Services unit.

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

When sending a written grievance, you will need to include a detailed description of the matter and include copies of any records or documents you think are relevant to the matter. We will acknowledge the complaint within ten working days of receipt of your complaint. We'll review the information and provide you with a written response within 20 working days of the receipt of the grievance, unless additional information is needed and it cannot be obtained within this timeframe. The response will explain what you need to do to seek an additional review. The investigation will be completed within 30 working days thereafter.

All disputes involving clinical decisions will be made by qualified clinical personnel.

If you don't agree with our response to your initial grievance, you can file an appeal

If we deny a claim, our reason for the denial will be explained in our response letter. To file an appeal, follow the directions in the letter or explanation of benefits statement that says your claim was denied. We will make a determination on the grievance within the timeframes listed in the chart below.

Second level review

You are entitled to a second level review by a committee if we uphold the denial at the first level of appeal. We will make a determination on the grievance within the timeframes listed in the chart below.

Aetna timeframe for responding to a grievance

Type of notice	Urgent care/ emergency care grievance	Pre-service grievance	Post-service grievance	Concurrent care grievance
Grievance Level 1 and Level 2	36 hours We will confirm our decision in writing within 3 working days of the initial decision	15 calendar days or 5 days after our investigation is complete (whichever is earlier).	20 working days* or 5 days after our investigation is complete (whichever is earlier).	As appropriate to type of claim
Extensions	None	None	30 calendar days	

* If we cannot make a decision within the timeframe listed, we will inform the member giving clear, specific reasons. We will however make a decision within 30 calendar days thereafter.

A “rush” review of an appeal may be possible

If your doctor thinks you cannot wait 15 days for an answer, you can ask for an “expedited review.” That means we will make our decision within 36 hours. You can do this for Level 1 or Level 2 appeals.

Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP)

You have the right to contact the director’s office at any time for help with any inquiry, grievance or appeal at:

Missouri Department of Insurance, Financial Institutions and Professional Registration

Office of the Director

301 West High Street Room 530

PO Box 690

Jefferson City, Missouri 65101

1-800-726-7390

Get a review from someone outside Aetna

You may be able to get an outside review if you’re not satisfied with your appeal if:

- The requested health care service (admission, availability of care, continued stay or other health care service) does not meet the health plan’s requirements for medical necessity, appropriateness of care, health care settings, level of care or effectiveness of a covered benefit
- The requested health care service has been found to be experimental or investigational
- You did not receive a timely decision from us
- Your coverage was rescinded

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 an outside expert. The expert will be a doctor or other professional who specializes in that area or type of appeal. You should have a decision within 30 calendar days of the request.

The outside reviewer’s decision is final and binding; we will follow the outside reviewer’s decision. We will also pay the cost of the review.

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** to view the list. You can also call Member Services at the number on your ID card to ask for a printed copy.

State regulatory agency

The state regulatory agency can help you understand your rights. Contact **http://insurance.mo.gov/** for more information about your rights in Missouri.

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:

- Ask your doctor for an advance directive form.
- Write your wishes down by yourself.
- Pick up a form at state or local offices on aging, bar associations, legal service programs or your local health department.

- Work with a lawyer to write an advance directive.
- Create an advance directive using computer software designed for this purpose.

Source: American Academy of Family Physicians. Advance Directives and Do Not Resuscitate Orders. January 2012.

Available at <https://familydoctor.org/advance-directives-and-do-not-resuscitate-orders/>
Accessed May 6, 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. 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) (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."

Member participation

We maintain a Membership Advisory Committee, approved by the Missouri Department of Insurance, to encourage members to participate in matters of our Policy and Operation.

You can contact the Membership Advisory Committee at:

Aetna Health Inc.

550 Maryville Centre Drive #300

St Louis, MO 63141

314-506-1700

<http://chcmisouri.coventryhealthcare.com>

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

When you lose your other coverage

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

When you have a new dependent

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

- Marriage
- Birth
- Adoption
- Placement for adoption

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

Aetna is committed to Accreditation by the National Committee for Quality Assurance (NCQA) as a means of demonstrating a commitment to continuous quality improvement and meeting customer expectations. A complete 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)

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

Za besplatne prevodilačke usluge pozovite 1-888-982-3862. (Serbo-Croatian)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-982-3862 an. (German)

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

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

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

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)

Um Schprooch Services zu griegie mitaus Koscht, ruff 1-888-982-3862. (Pennsylvania Dutch)

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

Tajaajiloota afaanii garuu bilisaa ati argaachuuf, bilibili 1-888-982-3862. (Cushite-Oromo)

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

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