

We offer quality health plans

By following health plan accreditation standards of the National Committee for Quality Assurance (NCQA), we offer quality health plans.

Understand your health plan

Your health plan covers preventive care and care you need for medical reasons. It includes care from a doctor or hospital — but it doesn't include everything.

What it doesn't cover

It doesn't cover services you may just want to have, like certain plastic surgeries. Or treatment that is not yet widely accepted. And some services may have limits. For example, a plan may allow only one eye exam a year.

Are you covered by two health plans?

If so, each plan may require you to follow its rules or use specific doctors and hospitals. You may not be able to collect benefits from both plans. Also, it may be impossible to comply with both plans at the same time. Before you enroll in one of our plans, read all of the rules and compare them with the rules of any other plan that covers you or your family.

Do you have a Med Premier or Student Plan?

For more information on these plans, you can:

- Visit **AetnaStudentHealth.com**
- Call Aetna Student Health at the toll-free number on your member ID card

If you disagree with our decision on coverage, write to us at either:

- The address on your Explanation of Benefits (EOB) statement
- The address on the letter we sent you

Fully insured student health insurance plans are underwritten by Aetna Life Insurance Company (Aetna). Aetna Student Health is the brand name for products and services provided by Aetna Life Insurance Company and its applicable affiliated companies (Aetna).

If you have questions about a Med Premier major medical plan, call The Boon Group® at the toll-free number on your member ID card. The Med Premier plan is a fully insured health insurance plan underwritten by Aetna Life Insurance Company.

Administrative services are provided by Aetna Life Insurance Company and Boon Administrative Services, Inc., a licensed third-party administrator and a wholly owned subsidiary of The Boon Group, Inc.

Not all the information in this document applies to your specific plan

Most information 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.

Some information may apply only to one or two states. It may not apply to your state. To be sure, review your plan documents. You can also ask your benefits administrator or call us. Some states' differences are not reflected in this document.

Lots of plan names

Plan document names vary. Look for plan details in documents with these names:

- Booklet-Certificate
- Schedule of Benefits
- Certificate of Coverage
- Group agreement

You can also find details in documents with these names:

- Group insurance certificate
- Group insurance policy

Can't find your plan documents?

Call us to ask for a copy. Use the toll-free number on your member ID card.

How to get the most out of your prescription drug benefits

First, check your plan documents to be sure you have prescription drug benefits. The list of drugs we cover is called the formulary. You can get this list two ways:

1. Go to **Aetna.com/formulary**.
2. Call us. We can send you a paper copy of the list of drugs we cover.

Remember: This list can change at any time. So look online or call us for the latest updates.

What's a generic drug?

Generic drugs are the same as brand-name drugs in dose, use, form and safety. You usually pay less for them. Brand-name drugs may cost you more.

What's a preferred drug?

Some plans encourage you to buy certain prescription drugs over others. You'll pay less for these drugs. We call these preferred drugs. When you get a drug that is not on the preferred drug list, you may pay more.

What's a mail-service pharmacy?

This is a convenient option if you must take certain drugs every day. Or if you take specialty medicines every day. Specialty drugs treat complex conditions like cancer.

What if your doctor wants you to take a drug that's not in our list?

If it is medically necessary for you to use that drug, then you, someone helping you, or your doctor can ask us to make an exception. Check your plan documents for details.

What is step therapy?

We may ask you to take one drug before you try another. Your doctor might want you to skip this drug for medical reasons. If so, your doctor can ask us to make an exception.

What is a medical exception?

Your plan documents might list specific drugs that we don't cover. Your plan also may not cover drugs that we haven't reviewed yet. You, someone helping you, or your doctor may ask us to cover one of these drugs.

What are drug rebates?

It's money back to us from the drug companies. We consider these when we decide which drugs to cover. Rebates help lower your costs.

How to find a mental health or addiction specialist

Get support for postpartum depression, addiction and other behavioral health issues. Call us at the number on your member ID card. You can also:

- Call **911** if it's an emergency
- Get help from your employee assistance program (EAP)
- Call the behavioral health number on your member ID card
- Go to [Aetna.com/individuals-families/find-a-doctor.html](https://www.aetna.com/individuals-families/find-a-doctor.html) to search for a provider

Before we decide to cover certain drugs and treatments, 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 them
- Ask other experts such as MCG, formerly Milliman Care Guidelines
- Check how often and how successfully a treatment or drug has been used

Once we decide, we publish our findings in our Clinical Policy Bulletins.

Get plan information online and by phone

Already enrolled in one of our health plans? You can:

- **Go to your member website**
When you go to [Aetna.com](https://www.aetna.com), you'll see a Login button. Click there to set up your user name and password. Have your member ID card handy.
- **Use our mobile app**
It's easy. Just download our Aetna HealthSM app or text "MOBILEAPP" to 90156.
- **Call us**
Just use the phone number on your member ID card. It's toll-free.

You can:

- Verify what's covered under your plan
- Check the status of a claim and get an address to mail your claim
- Order a replacement member ID card

And we can help you:

- Understand how your plan works
- Find out how much a service will cost you
- File a claim
- Find care outside your area

If your plan offers mental or behavioral health services, we can help you with these, too.

Hearing impaired? Need to speak with us?

Use your TTY and dial **711**. Once connected, enter the telephone number you're calling.

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



Speak another language?

Call us if you need an interpreter. Just use the number on your ID card.

How to search our network for doctors, hospitals and other health care providers

Already a member?

Go to **Aetna.com** and log in. Select “Find Care” and start your search.

Considering enrolling?

Go to **Aetna.com** and select “Find a doctor.” Choose the plan you’re interested in from the drop-down box.

What the search tool does

It can give you a list of doctors by ZIP code. Besides names and addresses, the tool tells you:

- Where the doctor went to medical school
- Gender
- Language spoken
- Hospital affiliation
- Driving directions
- Board certification status

What is an accountable care organization (ACO)?

An ACO is a special network. ACOs aim to better coordinate patient care. They’re made up of:

- Primary care doctors
- Specialists
- At least one hospital

How does an ACO work?

We pay ACOs more when they meet efficiency and quality goals such as:

- Increased screenings for cancer, diabetes and cholesterol
- Decreased emergency room visits, short-term hospital stays, repetitive tests and overall cost of care

Goals vary from network to network. The ACO has to pay us if it fails to meet its goals.

Does my health information get shared within the network?

Yes. This is because your doctors want to treat you based on your unique needs. To do that, they need to see a complete view of your health care.

How can I tell who’s in an ACO?

Our online provider search tool can help. Look for the network name in your search results.

Know the costs and rules for using your plan

Get to know these terms, which define how you pay for your health care:

- **Allowed amount** — this is the amount the provider gets.
- **Copay** — a set amount you pay for a covered health care service. You pay this at the time of service. Your copay for a specialist is more than for your family doctor.
- **Coinsurance** — you pay part of the bill and we pay part of the bill. It’s usually a percentage. Let’s say the allowed amount is \$100 and your coinsurance is 20 percent. You’d pay \$20, and we’d pay \$80 to the provider.
- **Deductible** — the amount you pay for covered services before your plan starts to pay.
- **Other deductibles** — these may apply at the same time:
 - **Inpatient hospital deductible:** You pay this when you are a patient in a hospital
 - **Emergency room deductible:** You pay this when you go to the emergency room. You *don't* have to pay this if you are admitted to the hospital within 24 hours.

In network and out of network — why it matters

If you go to a provider or hospital that is out of your plan’s network, you usually pay more. Simple as that.

Network-only plans

These plans cover health care services *only* when given by a doctor in the network. So, if you get services from an out-of-network doctor or other health care providers, you’ll pay more. For exceptions, refer to your plan documents.

Plans that cover out-of-network services

We do offer plans that cover some of your costs for out-of-network services. But you’ll still pay less if you go to a doctor in our network.

What does it mean when a doctor is in our network?

Doctors in our network have a contract with us. They agree on how much they will charge you for covered services. That amount is often less than what they would charge you if they were not in our network.

Doctors also agree to not bill you for any amount over their contract rate. All you have to pay is your coinsurance or copayments, along with any deductible. Your network doctor will handle any precertification your plan requires. (Precertification means getting our approval ahead of time.)

3 things to keep in mind if you're going to see an out-of-network doctor

1. The doctor may bill you for the amount we don't cover.
2. You'll pay higher copayments, coinsurance and deductibles under your plan.
3. Costs we don't cover — but you pay for — don't count toward your deductible or out-of-pocket limits.

Call us and ask how much you'll pay for seeing an out-of-network doctor

Go to **Aetna.com** to learn more about how we pay out-of-network benefits.

You don't need referrals with open access plans

If you have an open access or preferred provider organization (PPO) plan, you don't need a referral from your regular doctor to see a specialist. You also do not need to select a primary care physician (PCP). But it's a good idea to have one. That's because a PCP can help you navigate the health care system.

Getting our approval ahead of time

Sometimes we'll pay for care only if you get our approval before you get care. We call that precertification.

Usually you only need this for more serious care like surgery or being admitted to a hospital. When you get care from a doctor in our network, your doctor gets precertification from us. But if you get your care outside our network, you must call us for precertification.

Your plan documents list services that require precertification.

What happens if you don't get precertification?

You'll 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 doctors not in our network.

How do I start the precertification process?

Call the number on your member ID card. You must get the precertification *before* you receive the care — unless it's an emergency. You never have to get precertification for emergency services.

Remember, without precertification, you may have to pay all costs for:

- Health care
- Prescription drugs
- Medical equipment

What's a utilization review?

Sometimes, we review a case to be sure:

- The service or supply meets established guidelines
- It's a covered benefit under your plan

We follow these rules:

- We train our staff to focus on members getting the proper care.
- We don't reward practitioners or other individuals for denying coverage.
- We don't encourage staff members to make decisions that result in underutilization of health care services, nor do we reward employees who deny coverage.

What if it's an emergency?

- Call **911** or go to the nearest emergency room. If you have time, call your doctor.
- You don't have to get our OK for emergency services.
- Tell your doctor as soon as possible afterward. A friend or family member may call for you.

How to tell if it's a "real" emergency

- Your symptoms are sudden and severe.
- If you don't get help right away, you could die or face a real risk to your health. If you are pregnant, this includes your unborn child.

We cover emergency care anytime, anywhere in the world.

How you are covered for emergency care — wherever you are

Sometimes you don't have a choice about where you go for care. Maybe you're having a heart attack or you've been involved in a car accident. When you need care right away, go to any doctor, walk-in clinic, urgent care center or emergency room. You're covered.

OK, it's a real emergency. But how much will it cost me?

We'll pay the bill as if you got care in network. That means you'll have to pay only what you usually pay — your plan's copayments, coinsurance and deductibles. If we need more information, we'll get in touch with you.

After-hours care

Your doctor should have an answering service for times when you call after the office closes. You can also go to an urgent care center or a walk-in clinic. To find a center near you, log in to **Aetna.com** and search our list of doctors and other health care providers. Your plan documents can tell you how much you pay for these services.

Avoid unexpected bills

Before you go for health care, check your plan documents to see what's covered. Can't find your plan documents? No worries — just call us. Use the number on your member ID card. We can answer your questions about what's covered. We can also send you a paper copy of what your plan covers.

Not satisfied with our decision on your appeal?

If we based our decision on a medical judgment, you may be able to get a review from someone outside Aetna. Just follow the instructions on our response to your appeal.

You can either:

- Call us at the number on your member ID card for an external review form
- Visit **Aetna.com** and put “external review” in the search bar

In most cases, you will need to exhaust all of your internal appeals first.

What to do if you disagree with us

Tell us if you disagree with something we’ve done. You can talk to us on the phone. The phone number is on your member ID card. Or you can mail us a written complaint. Still not satisfied after talking to us? Then you can ask us to send your complaint to the right department.

Did we deny your claim? Directions on how to appeal our decision are in:

- The letter we sent you
- The Explanation of Benefits (EOB) statement that says your claim was denied

The letter we sent you tells you:

- What we need from you
- How soon we will respond

Understand your rights and responsibilities

How you can get to know your rights as a member

You have many legal rights as a member of a health plan. To see a full list, you can either:

- Go to **Aetna.com/individuals-families/member-rights-resources.html** to see the full list
- Get a paper copy by calling us at the number on your member ID card

Want to learn how we check on the quality of your care?

We make sure your doctor gives you and your family quality care. To learn how we do this, go to **Aetna.com**. Put “quality management and improvement efforts” in the search box. To get a paper copy, just call us using the toll-free number on your member ID card.

How Aetna guards your privacy

We’re committed to keeping your personal information private.

What personal information is — and what it isn’t

By “personal information,” we mean information that can identify you. It can include your financial and health information. It doesn’t include what the public can see easily. For example, anyone can look at what your plan covers. Another example: reports that do not name you.

How we get information about you

We get information about you from many places. First, of course, there’s you. But we also get information from your employer, from other insurers, or from health care providers, like doctors.

When it’s wrong

Do you think there’s something wrong or missing in your personal information? You can ask us to change it. The law says we must do this in a timely way. If we disagree with your change, you can file an appeal.

How we use the information about you

When the law allows us, we use your personal information both inside and outside our company. The law says we don’t need to get your OK when we do.

We may use it for your health care. We may use it to run our health plan. This means we may share it with doctors, dentists, pharmacies, hospitals or other caregivers. We also may share it with other insurers, vendors, government offices or third-party administrators (this includes plan sponsors and/or employers). But by law, all these parties must keep your information private.

We also may use your information when we pay claims or work with other insurers to pay claims. Or when we make plan decisions. We may use it when we do audits or study the quality of our work.

Sometimes we do need your permission to disclose your information

There are times when we do need your permission to disclose personal information. This is explained in our Notice of Privacy Practices. It took effect October 9, 2018. This notice clarifies how we use or disclose your Protected Health Information (PHI):

- For workers’ compensation purposes
- As required by law
- About people who have died
- For organ donation
- To fulfill our obligations for individual access and HIPAA compliance and enforcement

To get a copy of this notice, visit **Aetna.com**. Or call the toll-free number on your ID card.

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

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

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

See "Other Reports on Health Care Quality" in the drop-down menu for **Managed Behavioral Healthcare Organizations** for behavioral health accreditation and **Credentials Verifications Organizations** for credentialing certification.

If you need this material translated into another language, please call Member Services at 1-866-565-1236 (TTY: 711). Si usted necesita este material en otro lenguaje, por favor llame a Servicios al Miembro al 1-866-565-1236 (TTY: 711).