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Important information about your health benefits – New Jersey

Aetna Health Maintenance Organization (HMO) plans

www.aetna.com

01.28.325.1-NJ A (7/13)

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 that 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.

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Getting help

Contact Member Services with questions

Call the toll-free number on your ID card. Or, call **1-800-US-Aetna (1-800-872-3862)** Monday through Friday, 7 a.m. to 7 p.m. ET. You can also send Member Services an e-mail. Just go to your secure Aetna Navigator® member website at **www.aetna.com**. Click on "Contact Us" after you log in.

Member Services can help you:

- 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

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

It's important to know which doctors are in our network. That's because some health plans only let you visit doctors, hospitals and other health care providers if they are in our network. Some plans allow you to go outside the network. But, you pay less when you visit doctors in the network.

Here's how you can find out if your health care provider is in our network.

- Log in to your secure Aetna Navigator® member website at **www.aetna.com**. Follow the path to find a doctor and enter your doctor's name in the search field.
- Call us at the toll-free number on your Aetna ID card, or call us at **1-888-87-AETNA (1-888-872-3862)**.

For up-to-date information about how to find health care services, please follow the instructions above. If you would like a printed list of doctors, contact Member Services at the toll-free number on your Aetna ID card. Our online directory 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
- Gender

You can even get driving directions to the office. If you don't have Internet access, call Member Services to ask about this information.

* 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 provided by Aetna Health Inc.

Provider networks improve care while lowering costs
Members who receive care from providers from value-based arrangements are participating in a network designed to improve care while lowering costs. These networks may be set up in different ways, but all include primary care doctors and specialists. They also typically include at least one hospital.

Like most plans, we usually pay doctors and hospitals on a fee-for-service basis. This means your doctor or hospital still gets paid for each visit. However, the value-based network's mission is to better coordinate patient care to improve efficiency, quality and patient satisfaction.

We agree with the network on certain goals,* such as:

- Clinical performance goals – completing enough screenings for cancer, diabetes and cholesterol
- Cost-efficiency goals – reducing avoidable ER visits, short-term hospital stays, repetitive tests and the overall cost of care

We pay these value-based networks more when they meet certain goals. The amount of these payments depends on how well the network meets their goals. The network may also have to make payments to us if they fail to meet their goals.

In most of our arrangements we will reward the network financially for both efficient care and higher quality of care. This helps encourage savings that are tied to value and better health outcomes for our members.

Doctors and hospitals that are members of a value-based (accountable care) network may have their own financial arrangements through the network itself. Ask your doctor for details.

Choose a doctor the fast and easy way with DocFind®. Simply log on to your secure Aetna Navigator® website at **www.aetna.com** and select "Find a Doctor, Pharmacy or Facility." After entering your search criteria, look for the ACO logo Ⓐ. If you need a printed directory instead, call the Member Services phone number on your member ID card.

*The specific goals will vary from network to network.

Costs and rules for using your plan

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.
- In-network doctors and hospitals won't bill you for costs above our rates for covered services.
- You are in great hands with access to quality care from our national network.

Choose a primary care physician

You can choose any primary care provider 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 choose to be your PCP
Each member of the family may choose a different PCP from the Aetna network. Enter the name of the PCP you have chosen on your enrollment form. Or, call Member Services after you enroll to tell us your selection. The name of your PCP will appear on your Aetna ID card. You may change your selected PCP at any time. If you change your PCP, you will receive a new ID card.

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

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.

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

Do you need help in another language? Member Services can connect you to a special line where you can talk to someone in your own language. You can also get help with a complaint or appeal.

Language hotline – **1-888-982-3862** *(140 languages are available, ask for an interpreter.)*
TDD **1-800-628-3323** *(hearing impaired only)*

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

¿Necesita ayuda en otro idioma? Los representantes de Servicios al Miembro le pueden conectar a una línea especial donde puede hablar con alguien en su propio idioma. También puede obtener asistencia de un intérprete para presentar una queja o apelación.

Línea directa – **1-888-982-3862** *(Tenemos 140 idiomas disponibles. Debe pedir un intérprete.)*
TDD **1-800-628-3323** *(sólo para personas con impedimentos auditivos)*

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, $15) you pay for 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 percent (for example, 20%) 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% 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 specialist might recommend treatment or tests that were not on the original referral. In that case, you may need to get another referral from your PCP for those services.
- Women can go to an Ob/Gyn without a referral. See "PCP and referral rules for Ob/Gyns" below.
- Referrals are valid for one year as long as you are still a member of the plan. Your first visit must be within 90 days of the referral issue date.
- In 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.

Doctors, chiropractors and podiatrists must inform you of certain financial interests

Some doctors make referrals to other health care providers. They may refer you to doctors or facilities in which they have a significant financial interest. While they are allowed to do that, they must tell you about their financial interest at the time of the referral. If you want more information about this, contact your physician, chiropractor or podiatrist. If you believe that you are not receiving the information to which you are entitled, contact the Division of Consumer Affairs in the New Jersey Department of Law and Public Safety at **1-973-504-6200** OR **1-800-242-5846**.

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.

Call the number shown 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. We may suggest a different treatment or place of service that is just as effective but costs less. We also look to see if you qualify for one of our case management programs. If so, one of our nurses may contact you.

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

Paying primary care providers for quality

In some regions, PCPs can receive additional compensation based on performance on a variety of measures intended to evaluate the quality of care and services the PCPs provide to members. This additional compensation is based on the scores received on one or more of the following measures of the PCP's office: member satisfaction, percentage of members who visit the office at least annually, medical record reviews, the burden of illness of the members that have selected the PCP, management

of chronic illnesses like asthma, diabetes and congestive heart failure; whether the physician is accepting new patients, and participation in our electronic claims and referral submission program. We encourage you to ask your doctors and other health care providers how they are compensated for their services.

If you need more information about how we pay primary care physicians or any other provider in our network, please contact us at the toll-free number or address on your Aetna ID card. Otherwise call **1-888-982-3862** or write to: Aetna Health Inc., 55 Lane Road, Fairfield, NJ 07004.

Information about specific benefits

Coverage for children

A child who does not reside with you or does not reside in the service area is still eligible to enroll in your plan, provided the child complies with the terms and conditions of the plan with respect to the use of participating providers.

Dependent coverage to age 31

If you are a parent of an over-age dependent who is actively covered under a New Jersey issued group health contract, your dependent may be eligible for coverage to age 31 if you meet the eligibility requirement and elect coverage. For more information, please contact your employer, refer to your plan documents, or call Member Services at the number on your Aetna ID card.

Emergency and urgent care and care after office hours

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

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

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

How we cover out-of-network emergency care
You are covered for emergency and urgently needed care. You have this coverage while you are traveling or if you are near your home. That includes students who are away at school. When you need care right away, go to any doctor, walk-in clinic, urgent care center or emergency room. We'll review the information when the claim comes in. If we think the situation was not urgent, we might ask you for more information and may send you a form to fill out. Please complete the form, or call Member Services to give us the information over the phone.

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

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

Prescription drug benefit

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

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

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

When you get a drug that is not on the preferred drug list, 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 company rebates
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 list. They may also apply to drugs not on the list. In plans where you pay a percent 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 percent of the cost instead of a flat dollar amount, you may pay more for a drug on the preferred drug list than for a drug not on the list.

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

You might not have to stick to the list
Sometimes your doctor might recommend a drug that's not on the preferred drug list. 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.

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.

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

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

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

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

Mental health and addiction benefits

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

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

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

Mental health programs to help prevent depression

Aetna Behavioral Health offers two prevention programs for our members:

- Beginning Right® Depression Program: Perinatal Depression Education, Screening and Treatment Referral and
- SASDA: Identification and Referral of Substance Abuse Screening for Adolescents with Depression and/or Anxiety Prevention

Call Member Services for more information on either of these prevention programs. Ask for the phone number of your local Care Management Center.

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.

Breast reconstruction benefits

Notice regarding Women's Health and Cancer Rights Act of 1998

Coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

- All stages of reconstruction of the breast on which a mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of all stages of mastectomy, including lymph edemas

We will talk to you and your doctor about these rules when we provide the coverage. We will also follow your plan design. For example, the following may apply to your breast reconstruction benefits as outlined in your plan design:

- Limitations
- Copays
- Deductibles
- Referral requirements

If you have any questions about this coverage, please contact the Member Services number on your ID card.

Also, you can visit the following websites for more information:

U.S. Department of Health and Human Services – **http://cciio.cms.gov/programs/protections/WHCRA/whcra_factsheet.html**

U.S. Department of Labor – **www.dol.gov/ebsa/consumer_info_health.html**

Knowing what is covered

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

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

We check if it's "medically necessary"

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

The product or service:

- Must meet a normal standard for doctors
- Must be the right type in the right amount for the right length of time and for the right body part

- Must be known to help the particular symptom
- Cannot be for the member's or the doctor's convenience
- Cannot cost more than another service or product that is just as effective

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

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

We study the latest medical technology

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

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

- Read medical journals to see the research. We want to know how safe and effective it is.
- See what other medical and government groups say about it. That includes the federal Agency for Health Care Research and Quality.
- Ask experts.
- Check how often and how successfully it has been used.

We publish our decisions in our Clinical Policy Bulletins.

We post our findings on www.aetna.com

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

CPBs help us decide whether to approve a coverage request. Your plan may not cover everything our CPBs say is medically necessary. Each plan is different, so check your plan documents.

CPBs are not meant to advise you or your doctor on your care. Only your doctor can give you advice and treatment. Talk to your doctor about any CPB related to your coverage or condition.

You and your doctor can read our CPBs on our website at **www.aetna.com**. You can find them under "Individuals & Families." No Internet? Call Member Services at the toll-free number on your ID card. Ask for a copy of a CPB for any product or service.

We can help when more serious care is recommended

We may review a request for coverage to be sure the service is in line with recognized guidelines. Then we follow up. We call this "utilization management review."

It's a three step process:

First, we begin this process if your hospital stay lasts longer than what was approved. We make sure it is necessary for you to be in the hospital. We look at the level and quality of care you are getting.

Second, we begin planning your discharge. This process can begin at any time. We look to see if you may benefit from any of our programs. We might have a nurse case manager follow your progress. Or we might recommend that you try a wellness program after you're home.

Third, we may review your case after your discharge. We may look over your medical records and claims from your doctors and the hospital. We look to see that you got appropriate care. We also look for waste or unnecessary costs.

We follow specific rules to help us make your health a top concern:

- 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 claims. Physician's groups, such as independent practice associations, may use other resources they deem appropriate.

Claim procedures

With a network-only plan, you shouldn't need to file claims. Aetna participating doctors and other health care providers will file claims for you. For other plans or unusual situations, you may, at times, need to submit a claim form. You can download and print a claim form at **www.aetna.com/individuals-families-health-insurance/document-library/find-document-form.html**. You can also call Member Services at the number on your ID card to ask for a form. The claim form includes complete instructions, like what documentation to send with it.

Send the itemized bill for payment with the member's identification number clearly marked to the address shown on the member ID card. Claim payment will be made in accordance with the Claim Payment Procedure section of the Certificate of Coverage.

We will make a decision on the member's claim. For urgent care claims and preservice claims, we will send the member written notification of the determination, whether adverse or not adverse. For other types of claims, the member may only receive notice if we make an adverse benefit determination.

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

- Utilization Review – we determine that the service or supply is not medically necessary, is an experimental or investigational procedure, or is for dental or cosmetic purposes.
- No Coverage – we determine that a service or supply is not covered by the plan. A service or supply is not covered if it is not included in the list of covered benefits.

- It is excluded from coverage.
- An HMO limitation has been reached.
- Eligibility – we determine that the subscriber or subscriber's covered dependents are not eligible to be covered by the HMO plan.

All adverse benefit determinations to deny or limit an admission, service, procedure or extension of stay will be rendered by a physician.

Written notice of an adverse benefit determination will be provided to the member within the time frames shown below. Under certain circumstances, these time frames may be extended. The notice will provide important information that will assist the member in making an appeal of the adverse benefit determination if the member wishes to do so. Please see the Complaints and Appeals section for more information about appeals.

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

HMO Time Frame for Notification of an Adverse Benefit Determination

Type of Claim	HMO Response Time from Receipt of Claim
Urgent Care Claim. A claim for medical care or treatment where a delay could seriously jeopardize the life or health of the member, the ability of the member to regain maximum function; or subject the member to severe pain that cannot be adequately managed without the requested care or treatment.	As soon as possible but not later than 72 hours.
Preservice Claim. A claim for a benefit that requires preauthorization of the benefit before getting medical care.	Within 15 calendar days.
Concurrent Care Claim Extension. A request to extend a course of treatment previously preauthorized by Aetna.	If an urgent care claim, as soon as possible but not later than 24 hours. Otherwise, within 15 calendar days.
Concurrent Care Claim Reduction or Termination. Decision to reduce or terminate a course of treatment previously preauthorized by us. We will not deny coverage based on medical necessity for previously approved services unless the approval was based on material misrepresentation or fraudulent information submitted by the covered person or provider.	With enough advance notice to allow the member to appeal.
Postservice Claim. A claim for a benefit that is not a preservice claim.	Within 30 calendar days.

What to do if you disagree with us

Complaints, appeals and external review

We have procedures for members to use if they are dissatisfied with a decision that we have made or with our operations. The procedure the member needs to follow will depend on the type of issue or problem the member has.

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

The following chart summarizes some information about how appeals are handled for different types of claims:

HMO Time Frame for Responding to an Adverse Benefit Determination Appeal

Type of Claim	HMO Response Time from Receipt of Appeal	
	Level-One Appeal	Level-Two Appeal
Urgent Care Claim. A claim for medical care or treatment where a delay could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function or subject the member to severe pain that cannot be adequately managed without the requested care or treatment.	Within 36 hours Review provided by Aetna personnel not involved in making the adverse benefit determination.	Within 36 hours Review provided by Aetna Appeals Committee.
Preservice Claim. A claim for a benefit that requires approval of the benefit before getting medical care.	Within 5 business days Review provided by Aetna personnel not involved in making the adverse benefit determination.	Within 15 calendar days Review provided by Aetna Appeals Committee.
Concurrent Care Claim Extension. A request to extend or a decision to reduce a previously approved course of treatment.	Treated like an urgent care claim or a preservice claim depending on the circumstances.	Treated like an urgent care claim or a preservice claim depending on the circumstances.
Postservice Claim. Any claim for a benefit that is not a preservice claim.	Within 5 business days Review provided by Aetna personnel not involved in making the adverse benefit determination.	Within 20 business days Review provided by Aetna Appeals Committee.

A. Complaints
If the member is dissatisfied with the administrative services the member receives from us or wants to complain about a participating provider, call or write Member Services within 30 calendar days of the incident. The member will need to include a detailed description of the matter and include copies of any records or documents that the member thinks are relevant to the matter. We will review the information and provide the member with a written response within 30 calendar days of the receipt of the complaint, unless additional information is needed and it cannot be obtained within this time frame. The response will tell the member what he or she needs to do to seek an additional review.

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

A member, or a provider acting on behalf of a member and with the member's consent, dissatisfied with a utilization management adverse benefit determination will have the opportunity to appeal.

We provide for two levels of appeal of the adverse benefit determination. The member must complete the two levels of review before pursuing an appeal to an independent utilization review organization (IURO) or bringing a lawsuit against Aetna, unless serious or significant harm to the member has occurred or will imminently occur. If the member decides to appeal to the second level, the request must be made in writing within 60 calendar days from the date of our notice at the conclusion of the level-one appeal explaining the member's right to make a level-two appeal. Within 10 business days of receipt of a level-two appeal, we will acknowledge the appeal in writing.

The level-one appeal review will be conducted by a physician who was not the original reviewer nor a subordinate of the original reviewer who rendered the initial adverse benefit determination.

For a level-two appeal, we will conduct a same or similar specialty review for appeals involving clinical issues. In no event, however, will the consulting practitioner or professional have been involved in the utilization management determination at issue.

We maintain a formal internal utilization management appeal process (level two) whereby any member or provider acting on behalf of a member with the member's consent, who is dissatisfied with the results of a level-one appeal, shall have the opportunity to pursue his or her appeal before a panel of physicians and/or other health care professionals selected by Aetna who have not been involved in any of the previous utilization management decisions. The member and/or an authorized representative may attend the level-two appeal hearing and question the Aetna representatives and present his/her case.

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

In the event that we fail to comply with any of the deadlines for completion of the level-one appeal or level-two appeal, or in the event that we, for any reason, expressly waive our rights to an internal review of any appeal, then the member and/or provider may, at their option, proceed directly to the external appeals process set forth in section D.

D. External Appeal Process
Any member, or any provider acting on behalf of a member with the member's consent, who is dissatisfied with the result of the level-one appeal and level-two appeal process above, shall have the right to pursue their appeal to an independent utilization review organization (IURO) in accordance with the procedures set forth below.

Except as set forth in section C, the right to an external appeal under this section shall be contingent upon the member's full compliance with both stages of our level-one and level-two appeal processes.

1. Within 60 calendar days from receipt of the written determination of the level-two appeal panel, the member, or a provider acting on behalf of the member with the member's consent, shall file a written request with the Department of Banking and Insurance. The request shall be filed on forms, if applicable, provided to the member by Aetna and include both a filing fee and a general release executed by the member for all medical records pertinent to the appeal. The request shall be mailed to:

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

   You can download a copy of the "Application for the Independent Health Care Appeals Program" from **www.state.nj.us/dobi/index.html**.
2. The fee for filing an appeal shall be $25.00, payable by check or money order to the Department of Banking and Insurance. Upon a determination of financial hardship, the fee may be reduced to $2.00. Financial hardship may be demonstrated by the member through evidence of eligibility for either the Pharmaceutical Assistance to the Aged and Disabled, Medicaid, NJ FamilyCare, General Assistance, SSI, or New Jersey Unemployment Assistance.
3. Upon receipt of the appeal, together with the executed release and the appropriate fee, the Department of Banking and Insurance shall immediately assign the appeal to an IURO.
4. Upon receipt of the request for appeal from the Department of Banking and Insurance, the IURO shall conduct a preliminary review of the appeal and accept it for processing if it determines that:
   i. The individual was or is a member of Aetna
   ii. The service that is the subject of the complaint or appeal reasonably appears to be a covered benefit under the Certificate of Coverage
   iii. The member has fully complied with both the level-one and level-two appeal processes

iv. The member has provided all information required by the IURO and the Department of Banking and Insurance to make the preliminary determination including the appeal form and a copy of any information provided by us regarding our decision to deny, reduce, or terminate the covered benefit and a fully executed release to obtain any necessary medical records from us and any other relevant health care provider.

5. Upon completion of the preliminary review, the IURO shall immediately notify the member and/or provider in writing as to whether the appeal has been accepted for processing and if not so accepted, the reasons therefore.
6. Upon acceptance of the appeal for processing, the IURO shall conduct a full review to determine whether, as a result of our utilization management determination, the member was deprived of medically necessary covered benefits. In reaching this determination, the IURO shall take into consideration all pertinent medical records, consulting physician reports, and other documents submitted by the parties; any applicable, generally accepted practice guidelines developed by the Federal government and national or professional medical societies, boards and associations; and any applicable clinical protocols and/or practice guidelines that we have developed.
7. The full review referenced above shall initially be conducted by a registered, professional nurse or physician licensed to practice in New Jersey. When necessary, the IURO shall refer all cases for review to a consultant physician in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the appeal. All final recommendations of the IURO shall be approved by the medical director of the IURO.
8. The IURO shall complete its review and issue its recommended decision as soon as possible in accordance with the medical exigencies of the case which, except as provided for in this subsection, in no event shall exceed 30 business days from receipt of all documentation necessary to complete the review. The IURO may, however, extend its review for a reasonable period of time as may be necessary due to circumstances beyond its control. In such an event, the IURO shall, prior to the conclusion of the preliminary review, provide written notice to the member, to the Department of Banking and Insurance, and to Aetna, setting forth the status of its review and the specific reasons for the delay.
9. If the IURO determines that the member was deprived of medically necessary covered benefits, the IURO shall recommend to the member, Aetna, and the New Jersey Department of Health and Senior Services the appropriate covered health care services the member should receive.
10. Once the review is complete, we will abide by the decision of the IURO.
11. We will bear the cost of the IURO review.

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

F. Fees and Costs
Except as set forth in section D. 11 above for an external appeal, nothing herein shall be construed to require us to pay counsel fees or any other fees or costs incurred by a member in pursuing a complaint or appeal.

G. Addresses and Phone Numbers
For Aetna Health Inc.:
Aetna Complaints and Appeals
P.O. Box 14596
Lexington, KY 40512
1-888-982-3862 or the toll-free number on the member ID card.

For New Jersey Department of Banking and Insurance:
Office of Managed Care Consumer Protection Services
P.O. Box 325
Trenton, NJ 08625-0325
1-888-393-1062

For Aetna Life Insurance Company:
Aetna Complaints and Appeals
151 Farmington Avenue
Hartford, CT 06156
or call the toll-free number on your ID card.

Member rights & responsibilities

Know your rights as a member

You have many legal rights as a member of a health plan. You also have many responsibilities. You have the right to suggest changes in our policies and procedures, including our Member Rights and Responsibilities.

Below are just some of your rights. We also publish a list of rights and responsibilities on our website. Visit **www.aetna.com/individuals-families-health-insurance/member-guidelines/member-rights.html** to view the list. You can also call Member Services at the number on your ID card to ask for a printed copy.

Members have the right to:

- Available and accessible services when medically necessary, including availability of care 24 hours a day, 7 days a week for urgent or emergency conditions. For urgent or emergency conditions, call 911 or go to the nearest emergency facility
- Be treated with courtesy and consideration, and with respect for the member's dignity and need for privacy
- Be provided with information concerning our policies and procedures regarding products, services, providers, appeals procedures and other information about the organization and the care provided
- Choose a primary care provider within the limits of the covered benefits and availability and included as a participating provider in the plan network
- A choice of specialists among participating network providers following an authorized referral, subject to their availability to accept new patients
- Obtain a current directory of participating providers in the Aetna network upon request, including addresses, telephone numbers and a listing of providers who accept members who speak languages other than English
- Get help and referral to providers with experience in treatment of patients with chronic disabilities
- Receive from the member's physician(s) or provider, in terms the member understands, an explanation of his or her complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical

alternatives, whether or not these are covered benefits. If the member is not capable of understanding the information, the explanation shall be provided to his or her next of kin or guardian and documented in the member's medical record
- Be free from balance billing by providers for medically necessary services that were authorized or covered by the HMO plan except as permitted for copayments, coinsurance and deductibles by contract
- Formulate and have advance directives implemented
- All the rights afforded by law or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language the member understands
- Prompt notification of termination or changes in benefits, services or provider network
- File a complaint or appeal with Aetna or the Department of Banking and Insurance (20 West State Street, 9th Floor, P.O. Box 329, Trenton, NJ 08625-0329, Main phone: **1-609-292-5316**, Fax: **1-609-292-5865**) and to receive an answer to those complaints within a reasonable period of time

Independent consumer satisfaction surveys

A member of the general public may request independent consumer satisfaction results and an analysis of quality outcomes of health care services of managed care plans in the State of New Jersey. For a copy of the guide, call **1-888-393-1062**, or write the New Jersey Department of Banking and Insurance, P.O. Box 325, Trenton, NJ 08625-0325. The HMO Performance Report is available on the Department's website at: **www.state.nj.us/dobi/index.html** and may be viewed, printed or downloaded at no charge.

New Jersey QUITNET and New Jersey QUITLINE

Tobacco products pose a serious health threat in New Jersey, and cost the health insurance industry millions of dollars annually. The New Jersey Department of Health and Senior Services is providing two new free services that are available to consumers to help them kick the tobacco habit — the New Jersey Quitline (**1-866-NJ-STOPS** or **1-866-657-8677**) and the New Jersey Quitnet (**www.nj.quitnet.com**). The New Jersey Quitline provides individualized telephone-based counseling and referral programs for people who want to quit smoking and the New Jersey Quitnet offers personalized support and referrals online.

Making medical decisions before your procedure

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

There are three types of advanced directives:

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

You can create an advanced directive in several ways:

- Ask your doctor for an advanced 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 advanced directive.
- Create an advanced directive using computer software designed for this purpose.

Source: American Academy of Family Physicians. Advanced Directives and Do Not Resuscitate Orders. January 2012. Available at **http://familydoctor.org/familydoctor/en/healthcare-management/end-of-life-issues/advance-directives-and-do-not-resuscitate-orders.html**. Accessed April 2, 2013.

Learn about our quality management programs

We make sure your doctor provides quality care for you and your family. To learn more about these programs, go to our website at **www.aetna.com**. Enter "commitment to quality" in the search bar. You can also call Member Services to ask for a printed copy. See "Contact Member Services with questions" on page 2.

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 about your physical or mental health
- Information about the health care you receive
- Information about what your health care costs

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
- Those who pay for your health care services. That can include health care provider organizations and employers who fund their own health plans or who share the costs
- Other insurers
- Vendors
- Government authorities
- Third party administrators

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 health plans. If allowed by law, we usually will not ask if it's okay to use your information. However, we will ask for your permission to use your information for marketing purposes. We have policies in place if you are unable to give us permission to use your information. We are required to give you access to your information. You may also

request corrections to your personal information. We must fulfill your requests within a reasonable amount of time.

If you'd like a copy of our privacy policy, call the toll-free number on your ID card or visit us at **www.aetna.com**.

Anyone can get health care

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

We must comply with these laws:

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

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

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

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

When you lose your other coverage

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

Getting proof that you had previous coverage

We may ask for proof that you had previous coverage when you apply. Other insurers may do the same. This helps determine if you are eligible for the plan. Your plan sponsor may have contracted with us to issue a certificate. Ask us for a Certificate of Prior Health Coverage anytime you want to check the status of your coverage. If you lost your coverage, you have 24 months to make this request. Just call Member Services at the toll-free number on your ID card.

When you have a new dependent

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

- Marriage
- Birth
- Adoption
- Placement for adoption

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

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

To refine your search, we suggest you search these areas: Managed Behavioral Healthcare Organizations – for behavioral health accreditation; Credentials Verification Organizations – for credentialing certification; Health Insurance Plans – for HMO and PPO health plans; Physician and Physician Practices – for physicians recognized by NCQA in the areas of heart/stroke care, diabetes care, back pain and medical home. Providers who have been duly recognized by the NCQA Recognition Programs are annotated in the provider listings section of the Aetna provider directory.

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.

Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice.

Aetna does not provide care or guarantee access to health services. For up-to-date information, please visit our DocFind® directory at **www.aetna.com** or, if applicable, visit the NCQA's new top-level recognition listing at **recognition.ncqa.org**.

If you need this material translated into another language, please call Member Services at 1-800-323-9930.
Si usted necesita este material en otro lenguaje, por favor llame a Servicios al Miembro al 1-800-323-9930.

www.aetna.com

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