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Important information about your health benefits – Virginia

Aetna Health Maintenance Organization (HMO) plans

www.aetna.com

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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 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.

Virginia Service Area

The following counties and cities: Albemarle, Alexandria City, Amelia, Arlington, Buckingham, Caroline, Charles City, Charlotte, Charlottesville City, Chesterfield, Colonial Heights City, Cumberland, Dinwiddie, Fairfax, Fairfax City, Falls Church City, Fauquier, Fluvanna, Fredericksburg City, Goochland, Hanover, Henrico, Hopewell City, King George, King William, Loudoun, Louisa, Lunenburg, Manassas City, Manassas Park City, Nelson, New Kent, Nottoway, Petersburg City, Powhatan, Prince Edward, Prince George, Prince William, Richmond City, Spotsylvania, Stafford, and Westmoreland.

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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. Health benefits plans are provided by Aetna Health Inc.

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

Contact Virginia state officials
If you need to contact someone about this insurance for any reason, you may also contact your agent, if you have one. If you have been unable to contact us or your agent, or if you are not satisfied with the response, you may contact:

Virginia State Corporation Commission's Bureau of Insurance
Life and Health Division Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Phone: **804-371-9691**
Fax: **804-371-9944**

or

Office of the Managed Care Ombudsman Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Toll Free: **1-877-310-6560**
Richmond Metropolitan Area: **804-371-9032**
e-mail: **ombudsman@virginia.gov**

Written correspondence is preferred so they have a record of your inquiry. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

Aetna Life Insurance Company is regulated as a Managed Care Health Insurance Plan (MCHIP) and as such, is subject to regulation by both the Virginia State Corporation Commission Bureau of Insurance and the Virginia Department of Health.

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.

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.	

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.
- 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.

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.

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 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.

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.

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.

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

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.

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 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.

What to do if you disagree with us

Complaints, appeals and external review

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

The following is the exact procedure as outlined in your plan documents. However, know that you can always start the process or learn your next steps with a simple call to Member Services.

These procedures govern administrative complaints and grievances made or submitted by members.

A. Definitions

1. An "administrative complaint" is an oral or written contact from a member who expresses dissatisfaction regarding: i. The direct provision or quality of care by a participating health care provider; ii. The quality of administrative service provided by a participating health care provider; or iii. The quality of administrative service provided by Aetna.
2. An "adverse decision" means a utilization review determination by Aetna that: i. A health care service rendered or proposed to be rendered that would otherwise be covered under the member's contract is not or was not medically necessary, appropriate or efficient; and ii. May result in noncoverage of the health care service. An adverse decision does not include a decision concerning a person's status as a member.
3. An "appeal" means a request for reconsideration of a grievance.
4. A "final adverse decision" means a utilization review determination made by a physician advisor or peer of the treating health care provider in a reconsideration of an adverse decision, and upon which a provider or member may base an appeal.
5. A "grievance" means an oral or written request for reconsideration, filed by a member or health care provider on behalf of a member with Aetna through our internal grievance process regarding an adverse decision or administrative complaint concerning the member.
6. A "peer of the treating health care provider" means a physician or other health care professional who holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

B. Reconsideration of an Aetna Decision – Level I

1. Members with administrative complaints should contact us, either verbally or in writing, at the Aetna address and telephone number listed on the agreement. Administrative complaints will be routed to the appropriate Aetna department for resolution. If a member is not satisfied with

the resolution of their administrative complaint, they may file a written grievance. The grievance should contain sufficient information for us to investigate and render a decision.

2. Members who wish to request a reconsideration of an adverse decision should file a grievance with us at the following address and telephone numbers:

   National Complaint and Appeals Unit
   P.O. Box 981107
   El Paso, TX 79998-1107
   Fax: 859-425-3379
   Phone: Call the toll-free number on your Aetna ID card

3. The Complaint and Appeals unit will send a written notice to the member within two (2) working days of this initial contact. The notice will include the following:

   - An acknowledgement that the grievance was received
   - The name, address and telephone number of the Regional Grievance Unit
   - Instructions on how to submit written materials
   - The details of the internal appeal process and procedures
   - If necessary for the review, a release form for the member's signature for the purpose of obtaining medical records or other information that may require their authorization for release
   - Information about the Bureau of Insurance's Managed Care Ombudsman including the following mailing address, telephone number and e-mail address:

     Office of the Managed Care Ombudsman
     Bureau of Insurance
     P.O. Box 1157
     Richmond, VA 23218
     Toll Free: **1-877-310-6560**
     Richmond Metropolitan Area: **804-371-9032**
     e-mail: **ombudsman@virginia.gov**

Grievances will be handled as follows: The Regional Grievance Unit will review all of the information submitted and gather any additional information necessary to prepare and render a decision about the grievance. If there is insufficient information available to make a decision the Regional Grievance Unit will, within five (5) working days of receipt of the grievance, notify the member or health care provider on behalf of the member, of the need for additional information.

The Regional Grievance Unit will also offer to assist the member or health care provider obtain the information. The Regional Grievance Unit will review, render a final adverse decision or grievance decision and send a written notice to the member or the health care provider, if filed on behalf of the member, within 10 working days of receipt of the grievance.

This notice will include:

- The decision, in clear terms, with the contractual (benefits) or clinical (medical appropriateness) rationale
- A statement that a list of individuals participating in the review of the grievance, along with their titles and credentials, is available on request
- A statement of the reviewer's understanding of the pertinent facts of the grievance
- A reference to the specific criteria and standards, including interpretive guidelines on which the decision was based
- A reference to the evidence or documentation used as the basis for the decision
- If the decision is upheld, a description of the member's right to an appeal hearing and the procedure for requesting the hearing

C. Appeal Hearing – Level II

1. The Member has 30 days from the notification of the Level I decision to request a Level II appeal hearing.

2. Upon receipt of a written request for a Level II appeal hearing, we will provide the member filing the request with the procedures governing appeal hearings. The member will be notified of the member's right to have an uninvolved Aetna representative available to assist the member in understanding the appeal hearing process.

3. A review body at the local market (hereinafter the "Appeal Hearing Panel") will be formed to handle the appeal hearing. The reviewers must not have participated in any prior review determinations. The composition of the review body must be peers of the treating health care provider (physician to physician; chiropractor to chiropractor) and must be board certified or board eligible in a discipline pertinent to the issue under review, if the appeal involves a medical necessity issue.

4. We will hold appeal hearings in our offices on a certain day each month to consider all appeals filed seven (7) working days or more in advance of the hearing day. We will send written notification to the member indicating the time, date and location of the hearing.

5. In the event a member is unable to attend the hearing on the scheduled hearing day, the appeal will be heard in the member's absence.

6. The member will have the right to attend the appeal hearing, question the Aetna representative designated to appear at the hearing and any other witnesses, and present their case. The member will also have the right to be assisted or represented by a person of the member's choice, and to submit written material in support of their appeal. The member may bring a physician or other expert(s) to testify on the member's behalf. We will also have the right to present witnesses. Counsel for the member may present the member's case and question witnesses; if the member is so represented. Similarly, we may also choose to be represented by counsel. The Appeal Hearing Panel will have the right to question the Aetna representative, the member and any other witnesses.

7. The appeal hearing will be informal. The Appeal Hearing Panel will not apply formal rules of evidence in reviewing documentation or accepting testimony at the hearing. The Chair of the Appeal Hearing Panel will have the right to exclude redundant testimony or excessive argument by any party or witness.

8. A written record of the appeal hearing will be made by stenographic transcription. All testimony will be under oath.

9. Before the record is closed, the Chair of the Appeal Hearing Panel will ask both the member and the Aetna representative (or their counsel) whether there is any additional evidence or

argument the party wishes to present to the Appeal Hearing Panel. Once all evidence and arguments have been received, the record of the appeal hearing will be closed. The deliberations of the Appeal Hearing Panel will be confidential and will not be transcribed.

10. The Appeal Hearing Panel will render a written decision within five (5) working days of the conclusion of the appeal hearing.
11. The Appeal Hearing decision will be made within 30 days of receipt of the members' request. The written decision will contain:
    - The decision, in clear terms, with the contractual (benefits) or clinical (medical appropriateness) rationale
    - A statement that a list of individuals participating in the review of the appeal, along with their titles and credentials, is available on request
    - A statement of the Appeal Hearing Panel's understanding of the pertinent facts of the appeal
    - A reference to the evidence or documentation used as the basis for the decision, and in the cases involving a denial of services, instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used

D. External Review

We also offer members an external review process. This process allows members to have their adverse decisions reviewed by an Independent Utilization Review Organization. A member may obtain an external review of their coverage denial from an Aetna contracted External Review Organization ("ERO") if the denial is based on the lack of medical necessity or the experimental or investigational nature of the proposed treatment. Instructions on how to request an external review are included with the Appeal Hearing Panel's response to the second level appeal.

E. Expedited Review of Adverse Decisions

1. The member or health care provider on behalf of the member, may request an expedited review when an adverse decision is rendered for health care services that are proposed but have not been delivered, and the services are necessary to treat a condition or illness that, without immediate medical attention, would seriously jeopardize the life or health of the member or the member's ability to regain maximum function, or would cause the member to be a danger to him/herself or others. The member and health care provider will be notified immediately if we do not have sufficient information to complete the expedited review and we will assist the member or health care provider in gathering the necessary information without further delay.
2. Expedited reviews will be performed by a physician advisor, a peer of the treating health care provider or a panel of other appropriate health care providers, at least one of which is a physician advisor.
3. Expedited reviews will be completed within 24 hours of the time the member or health care provider initiates the request.
4. Within one (1) day after a decision has been orally communicated to the member or health care provider, a written notice will be sent to the member or health care provider. The notice will include:
    - The decision, in clear terms, with the contractual (benefits) or clinical (medical appropriateness) rationale
    - A list of individuals participating in the review, along with their titles and credentials, is available on request
    - A statement of the reviewer's understanding of the pertinent facts of the review
    - A reference to the evidence or documentation used as the basis for the decision, and in cases involving a denial of services, instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used
    - If the denial is upheld, a statement advising the member or health care provider of their right to file a grievance and a description of how to file a grievance
    - Information about the Bureau of Insurance's Managed Care Ombudsman including the following mailing address, telephone number and e-mail address:

      Office of the Managed Care Ombudsman Bureau of Insurance
      P.O. Box 1157
      Richmond, VA 23218
      Toll Free: **1-877-310-6560**
      Richmond Metropolitan Area: **804-371-9032**
      e-mail: **ombudsman@scc.state.va.us**
5. If the expedited review is a concurrent review determination, the service should be continued without liability to the member until the member is notified of the decision, unless it is related to an initial unauthorized admission.
6. We are not required to provide an expedited review for retrospective noncertifications.

F. Record Retention

We will retain the records of all grievances and appeals for a period of at least seven (7) years.

G. Fees and Costs

Nothing herein will be construed to require us to pay counsel fees or any other fees or costs incurred by a member in pursuing a grievance or appeal. We are subject to regulation in the Commonwealth of Virginia by the State Corporation Commission Bureau of Insurance, pursuant to Title 38.2, and the Virginia Department of Health, pursuant to Title 32.1.

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. 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 **www.aetna.com**. Click on "Rights & Resources" on the home page to view the list. You can also call Member Services at the number on your ID card to ask for a printed copy.

Making medical decisions before your procedure

An "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 3.

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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