Important information about your health benefits – New York

For Aetna Open Access® Elect Choice® EPO, Open Choice® PPO, Managed Choice® POS and Aetna Open Access Managed Choice plans.

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 your plan includes those provisions.

Where to find information about your specific plan

Your plan documents list all the details for your plan, such as what's covered, what's not covered and the specific amounts that you will pay for services. Plan document names vary. They may include a Booklet-certificate, Group Agreement and Group Insurance Certificate, Group 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.

Have a Student Plan?

If you have a Student Accident and Sickness plan please visit **www.aetnastudenthealth.com** for questions or call Aetna Student Health at the toll-free number on your ID card for more information. For appeals, please forward your request to Chickering Claims Administrators, Inc., P.O. Box 15717, Boston, MA 02215-0014. Fully insured student health insurance plans are underwritten by Aetna Life Insurance Company (ALIC) and administered by Chickering

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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 and/or administered by Aetna Health Inc. and/or Aetna Life Insurance Company.

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Claims Administrators, Inc. (CCA). Self-insured plans are funded by the applicable school, with claims administration services provided by Chickering Claims Administrators, Inc. Aetna Student Health is the brand name for products and services provided by ALIC and CCA.

Getting help

Contact us

Member Services can help with your questions. To contact Member Services, call the toll-free number on your ID card. 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 on.

Member Services can help you:

- Choose or change your PCP
- 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
- And more

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

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

Language hotline – **1-888-982-3862** *(140 languages are available. You must 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)*

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

Even though you may visit any licensed doctor — in or out of the Aetna network of physicians — it's important to know which doctors are in our network. You generally 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 on 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. If you don't have your card, you can call us at **1-888-87-AETNA (1-888-872-3862).**

We cannot guarantee that a doctor will be available or taking new patients. The best way to be sure is to call the doctor's office directly and ask.

For up-to-date information about how to find inpatient and outpatient services, partial hospitalization and other behavioral health care services, please follow the instructions above. If you do not have Internet access and would like a printed list of providers, please contact Member Services at the toll-free number on your Aetna ID card to ask for a copy.

Our online directory is more than just a list of doctor's names and addresses. It also includes information about where the physician attended medical school, board certification status, language spoken, gender and more. You can even get driving directions to the office. If you don't have Internet access, you can call Member Services to ask about this information.

Costs and rules for using your plan

What you pay

Besides paying your monthly premium, 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 fixed amount (for example, $15) you pay for covered health care services. You usually pay this when you receive the service. The amount can vary by the type of service. For example, the copay for your primary doctor's office visit may be different than a specialist's office visit.

- Coinsurance – Your share of the costs of a covered service. Coinsurance is calculated as 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 – Some plans include a deductible. The amount you owe for health care services before your health plan begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you have paid $1,000 for any covered health care services that are subject to the deductible. The deductible may not apply to all services. Other deductibles may apply at the same time:
  - Inpatient Hospital Deductible – This deductible applies when you are a patient in a hospital.
  - Emergency Room Deductible – 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.

The Inpatient Hospital and Emergency Room Deductibles are separate from your general deductible. For example, your plan may have an overall $1,000 deductible and also has a $250 Emergency Room Deductible. This means that you pay the first $1,000 before the plan pays anything. Once the plan starts to pay, if you go to the emergency room you will pay the first $250 of that bill.

Your costs when you go outside the network

Network-only plans

Open Access Elect Choice EPO plans 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.

Plans that cover out-of-network services

Open Choice and Open Access Managed Choice plans: You may choose a doctor in our network, or go outside the network. We cover the cost of care based on if the provider, such as a doctor or hospital, is "in network" or "out of network." We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this care.

Managed Choice plans: You may choose a doctor in our network, with or without a PCP referral. You may go outside the network for your health care. We cover the cost of care based on your choices. You must get a PCP referral to in-network doctors to receive the highest level of benefits for specialty care. (See the "Referrals" section for more about this.) If you don't get a referral, your benefit will be paid at the "nonreferred" or "nonpreferred" level. This is the same level of benefits as if you went to an out-of-network doctor.

"In network" - This means we have a contract with that doctor. He agrees to how much he will charge you for covered services. That amount is often less than what he would charge you if he was not in our network. Most of the time it costs you less to use doctors in our network. Most plans pay a higher percentage of the bill if you stay in network. The doctor agrees he won't bill you for any amount over his contract rate. All you have to pay is your coinsurance or copayments, along with any deductible. Your network doctor will handle any precertification required by your plan.

"Out of network" means that we do not have a contract for discounted rates with that doctor. With Managed Choice plans, these benefits will be paid at the "nonreferred/nonpreferred" benefit level. We don't know exactly what an out-of-network doctor will charge you. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor.

Your out-of-network doctor or hospital sets the rate to charge you. It may be higher – sometimes much higher – than what your Aetna plan "recognizes" or "allows." Your doctor may bill you for the dollar amount that Aetna doesn't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket limits. This means that you are fully responsible for paying everything above the amount that Aetna allows for a service or procedure.

How we pay your doctor and other health care providers

Participating doctors are independent practicing physicians who are neither employed nor exclusively contracted with Aetna. Individual doctors and other health care providers are in the network by either directly contracting with Aetna and/or affiliating with a group or organization that contract with us.

There are several ways that we pay doctors and other health care providers who are in the Aetna network:

- Per individual service or case (fee for service at contracted rates)
- Per hospital day (per diem contracted rates)

- Capitation (a prepaid amount per member, per month)
- Through integrated delivery systems (IDS), independent practice associations (IPA), physician hospital organizations (PHO), physician medical groups (PMG), behavioral health organizations and similar provider organizations or groups. We pay these organizations, which in turn may reimburse the doctor, provider organization or facility directly or indirectly for covered services. In such arrangements, the group or organization has a financial incentive to control the cost of care

When you choose to see an out-of-network doctor, hospital or other health care provider, Aetna pays for your health care using a "prevailing" or "reasonable" charge obtained from an industry database; a rate based on what Medicare would pay for that service; or a local market fee set by Aetna. Your plan will state which method is used.

This way of paying out–of–network doctors and hospitals applies when you choose to get care out of network.

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

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

See which rules apply to your plan

Each plan is different. Some plans have requirements that others do not. Check the chart below to see what applies to your plan. If you're still not sure, read your plan documents or your summary of benefits. This booklet will help you know more about each requirement.

Choose a primary care physician (PCP)

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

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

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

A female member may choose an Ob/Gyn as her PCP. You may also choose a pediatrician for your child(ren)'s PCP. Your Ob/Gyn acting as your PCP will provide the same services and follow the same guidelines as any other PCP. They will issue referrals to other doctors (if your plan requires referrals) and they will get all required approvals and comply with any preapproved treatment plans. See the sections about referrals and precertification for more about those requirements.

You can search our DocFind® directory at **www.aetna.com** for PCPs who participate in the Aetna network.

Tell us who you chose to be your PCP

You may choose a different PCP from the Aetna network for each member of your family. 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. Just call Member Services at the toll-free number on your Aetna ID card. If you change your PCP, you will receive a new ID card. The change will become effective when we approve the request.

Making your specialist your PCP

If you have a life-threatening disease or a degenerative medical condition and need specialized care over a long period of time, you may ask to have your specialist serve as your PCP. Call Member Services at **1-888-982-3862** to make this request.

Product	PCP Page 4	Referrals Page 5	Precertification Page 5	Out-of-network benefits Page 3
Open Choice	No	No	Yes	Yes
Managed Choice	Yes, to get the highest level of benefits	Yes, to get the highest level of benefits	Yes	Yes
Aetna Open Access Managed Choice	No, but you may want one	No	Yes	Yes
Aetna Open Access Elect Choice	No, but you may want one	No	Yes	No

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

You never need to get a referral if you have an Aetna Open Access Elect Choice, Aetna Open Access Managed Choice or Open Choice plan. With the Managed Choice plan, you will receive the highest level of benefits under the plan when you get a referral from your PCP before you see a network specialist.

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

A referral from your PCP is not the same thing as getting approval (called "precertification") from the plan. Some health care services require both. For more information, read the "Precertification: Getting approvals for services" section of this booklet.

Remember these points about referrals:

- You do not need a referral for emergency care or urgent care
- You do not need a referral for covered routine gynecology, routine eye exams, annual age-appropriate mammograms or routine prenatal care.
- If you do not get a referral when required, the plan will pay for the service as an out-of-network benefit, if available.
- 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.
- You can get a special referral to go outside the network if a network specialist is not available for your health care needs. With a special referral, your covered expenses will be paid at the highest benefits level.

Standing referrals
If you have a medical condition and need ongoing care from a specialist, you may request a standing referral from us or your PCP to see that specialist continuously to treat your condition.

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 Ob/Gyns

A female member can choose an Ob/Gyn as her PCP. Women can also go to any obstetrician or gynecologist who participates in the Aetna network without a referral or prior authorization. Visits can be for checkups, including breast exams, mammograms and Pap smears, and for 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." Precertification is usually limited to more serious care like surgery or being admitted to a nursing home. Your plan documents list all the services that require precertification. When you get care from a doctor in the Aetna network, your doctor takes care of precertification. But if you get your care outside our network, you must call us for precertification when that's required. If you don't, you will have to pay for the service. Even with precertification, if you receive services from an out-of-network provider, you will usually pay more.

Call the number shown on your Aetna ID card to begin the process. You must get the approval before you receive the care.

Precertification is not required for emergency services.

What we look for when reviewing a precertification request
First, we check to see that you are still a member. And we make sure the service is a covered expense under your plan. We also check that the service and place requested to perform the service is cost effective. If we know of a treatment or place of service that is just as effective but costs less, we may talk to your doctor about it.

We also look to see if you qualify for one of our case management programs. If so, one of our nurses may call to tell you about it and help you understand your upcoming procedure.

If your doctor is not in or leaves the network

For Managed Choice and Open Access Managed Choice plans, you get the highest level of benefits when you stay in the network for health care services. If your doctor leaves the network while you're in the middle of a treatment plan, you can ask us if it's okay to continue seeing that doctor for up to 90 days and still be considered "in the network." This allows you time to transition to a new network doctor. Woman who are in their second trimester of pregnancy may continue seeing their obstetrician or women's health care specialist throughout the remainder of their pregnancy and post-partum care.

Under the same medical circumstances as above, if you're new to the plan and your current doctor is not in the network, you may ask to keep seeing that doctor for up to 60 days.

To be approved, the out-of-network doctor must agree to our terms and conditions of quality of service and payment rates for covered services. Also, we will not approve a request if the doctor was terminated from the network because of fraud, imminent harm to patient care or disciplinary action from the state licensing board.

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 a delay would not risk your health, 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.
- Emergency care services do not require precertification.

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.

If you have a PCP, see your PCP for all follow-up care to receive the highest level of benefits.

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.

Your plan pays out-of-network benefits when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance, and deductibles for your in-network level of benefits. Under federal health care reform (Affordable Care Act), the government will allow some plans an exception to this rule. Contact Aetna if your provider asks you to pay more. We will help you determine if you need to pay that bill.

After-hours care — available 24/7

Call your doctor anytime if 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 on 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

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 them. You'll not only pay your normal share of the cost, 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, you usually will pay more. Check your plan documents to see how much you will pay. If your plan has an "open formulary," that means you can use those drugs, but you'll pay the highest copay under the plan. If your plan has a "closed formulary," those drugs are not covered.

Drug Manufacturer Rebates
Drug manufacturers may give us rebates when our members buy certain drugs. We may share those rebates with your employer. While those rebates for the most part apply to drugs on the Preferred Drug List, they may also apply to drugs not on the Preferred Drug List. But, in any case, in plans where you pay a percent of the cost, your share of the cost is based on the price of the drug before any rebate is received by Aetna.

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 are from Aetna-owned pharmacies
Aetna Rx Home Delivery and Aetna Specialty Pharmacy are pharmacies that Aetna owns. Your health plan pays claims for drugs that it covers. These claims generally cost more than what participating network pharmacies, including Aetna Rx Home Delivery and Aetna Specialty Pharmacy, pay for the drugs.

You might not have to stick to the list
If it is medically necessary for you to use a drug that's not on your plan's preferred drug list, you or your doctor (or pharmacist in the case of antibiotics and pain medicines) can ask us to make an exception. 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 "prerequisite" 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 or your doctor (or pharmacist in the case of antibiotics and pain medicines) can ask for a medical exception.

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 or your doctor may have to get our approval to use one of these new drugs.

Get a copy of the preferred drug list
The Aetna Preferred Drug Guide is posted to our website at **www.aetna.com/formulary/**. If you don't use the Internet, you can ask for a printed copy. Just call Member Services at 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.

Have questions? Get answers!
Ask your doctor about specific medications. Call Member Services (at the number on your ID card) to ask about how your plan pays for them. Your plan documents also spell out what's covered and what is not.

Behavioral health and substance abuse benefits

With Elect Choice plans, you must use behavioral health professionals who are in the Aetna network. With all other plans, you can use any licensed behavior health provider, in or out of the Aetna network.

Here's how to get behavioral health services

- Emergency services – call 911.
- Call the toll-free Behavioral Health number on your Aetna ID card.
- If no other number is listed, call Member Services.
- If you're using your employer's or school's EAP program, the EAP professional can help you find a behavioral health specialist.

If you are going outside the network, you are responsible for getting precertification when required. You can access most outpatient therapy services without precertification. However, you should first consult Member Services to confirm that any such outpatient therapy services do not require precertification.

Read about behavioral health provider safety
We want you to feel good about using the Aetna network for behavioral 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.

Behavioral 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

For more information on either of these prevention programs and how to enroll in the programs, ask Member Services for the phone number of your local Care Management Center.

Breast reconstruction benefits

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the 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:

(1) all stages of reconstruction of the breast on which a mastectomy has been performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;

(3) prostheses; and

(4) treatment of physical complications of all stages of mastectomy, including lymph edemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

For more information, you can visit this U.S. Department of Health and Human Services website, **www.cms.hhs.gov/HealthInsReformforConsume/06_TheWomen'sHealthandCancerRightsAct.asp#TopOfPage** and this U.S. Department of Labor website: **www.dol.gov/ebsa/consumer_info_health.html**.

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 usually need to use 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.

Knowing what is covered

You can avoid receiving an unexpected bill with a simple call to Member Services. You can find out if your preventive care service, diagnostic test or other treatment is a covered benefit — before you receive care — just by calling the toll-free number on your ID card.

We have developed a patient management program to help determine what health care services are covered under the health plan and the extent of such coverage. The program helps patients get appropriate health care and maximize coverage for those health care services.

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

We study the latest medical technology

To help us decide what is medically necessary, we may look at scientific evidence published in medical journals. 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 The Milliman Care Guidelines.

We also review the latest medical technology, including drugs, equipment — even 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

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

CPBs tell if we view a product or service as medically necessary. They also help us decide whether to approve a coverage request. But your plan may not cover everything that 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** 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 particular product or service.

We check if it's "medically necessary"

Medical necessity is more than a procedure being ordered by a doctor. "Medically necessary" means your doctor or health care professional 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. It also has to 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 deny coverage if the reason is medical necessity. We do not give financial incentives or otherwise to Aetna employees for denying coverage.

Sometimes the review of medical necessity is handled by a physicians' group. Those groups might use different resources than we do.

Not every service, supply or prescription drug that fits the description of medically necessary is covered by the plan. Your plan may specifically exclude a certain service or place limits on them. For example, some benefits are limited to a certain number of days or visits, or they might have a maximum dollar limit. Read your Summary of Benefits under "What the Plan Covers" to learn more.

If we deny coverage, we'll send you and your doctor a letter. The letter will tell you why we denied the claim. It will also explain how to appeal the denial to the New York State External Review Program. You have the same right to appeal if a physician's group denied coverage for medical necessity. You can call Member Services to ask for a free copy of the criteria 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.

Utilization review

"Utilization review" means the review to determine whether health care services that have been provided, are being provided or are proposed to be provided are medically necessary or are experimental or investigational procedures. An "adverse determination" means we have determined that an admission, extension of stay, or other health care services is not medically necessary.

Where such use is appropriate, our Utilization Review/Patient Management staff uses nationally recognized guidelines and resources, such as The Milliman Care Guidelines® to guide these processes. When provider groups, such as independent practice associations, are responsible for these steps, they may use other criteria that they deem appropriate.

To contact the Utilization Review Agent, call **1-888-982-3862** weekdays from 8 a.m. to 4 p.m ET. After hours, you can leave a message. If your doctor has a question about your coverage, he or she may call or write to our Patient Management department at the address or phone number shown on your Aetna ID card.

Prospective review

Prospective review, (preservice review) is the review for approval of a claim before the service has taken place. We will tell you our decision within three business days after we receive the claim. We will notify you or your designee and your doctor by phone and in writing. If we ask for more information, you and your doctor have 45 calendar days to submit the information. We will make a decision within 3 business days after we receive the information. If we do not receive the needed information, we shall make our decision within 15 days from the end of the 45th day.

If the request is for urgently needed care, we will notify you (or your designee and doctor) by phone and in writing within 24 hours after we receive the claim. If more information is needed, we will ask for it within 24 hours. You (or your designee and doctor) will have 48 hours to submit the needed information. We will make our decision and notify you (or your designee and doctor) by phone and in writing within 48 hours after we request the information.

Concurrent review

We begin a "concurrent review" if your hospital stay lasts longer than what was approved. We verify that it is necessary for you to still be in the hospital. We look at the level and quality of care you are getting. We will communicate our decision to you, your designee or your doctor within one business day by phone and in writing. If we need more information to make a decision, we will make the decision no later than one business day after we receive all needed information or within 15 calendar days of the request, whichever is earlier.

If the request is for an urgent matter, we will make a determination and will notify the you, your designee and/or your doctor by phone and in writing within 24 hours after we receive the request.

It we have previously approved a course of treatment, we will not reduce or terminate the approved services before giving you enough prior notice of the reduction or termination so you can complete the appeal process before the services are reduced or terminated.

Discharge planning
Discharge planning may be initiated at any stage of the patient management process. It begins as soon as we know of your post-discharge needs, which we can learn through the precertification or concurrent review processes. 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 get back home.

Retrospective record review
After you are home and we receive the claim for the services you received, we will review your case. This is called a "retrospective review." 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 will make a decision to pay the claim in writing as soon as possible but not later than 30 calendar days after we receive the claim. If needed, we will give you 45 days to send in any necessary information. We will make a decision within 15 days after we receive this information. After 45 days, we will make a decision based on the information we had and will notify you of the decision within 15 days.

Reconsideration review
In the event that an adverse determination is made without attempting to discuss the matter with your doctor who recommended the health care service, procedure or treatment under review, the doctor has an opportunity to ask for reconsideration through discussion with the clinical peer reviewer. Reconsideration occurs within one business day of when we receive the request. Reconsideration does not apply to retrospective reviews.

We may reverse a preauthorized treatment service or procedure retrospectively in these instances:

1. When the relevant medical information presented to us is materially different from the information presented during the original preauthorization
2. When the relevant medical information presented to us during the retrospective review existed at the time of preauthorization, but was withheld from or not made available to us; and
3. We were not aware of the existence of the information at the time of the preauthorization review; and
4. If we had been aware of this information, the treatment service or procedure being requested would not have been authorized. The determination is to be made using the same specific standards, criteria or procedures as used during the preauthorization review.

You have the right to designate a representative to act on your behalf, or to have any person who has legal responsibility to make medical care decisions for you.

All clinical denials will be made by a clinical peer reviewer and all denial notices will contain information about the basis for the decision.

What to do if you disagree with us

We want to hear from you if you disagree with a business practice or a coverage denial. At any time during the complaints process, you have the right to contact the New York State Department of Health at 1-800-206-8125, or by mail at New York State Department of Health, Division of Managed Care, Bureau of Managed Care Certification and Surveillance, Empire State Plaza, Corning Tower, Room 1911, Albany, New York 12237-0062.

Call Member Services to file a verbal complaint or to ask for the appropriate address to mail a written complaint. The phone number is on your Aetna ID card. You can also e-mail Member Services through the secure member website. We will respond to your complaint within 15 calendar days, unless we need additional information. Our response will tell you what to do if you need further review.

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

If you don't agree with a denied claim or precertification request, you can file an appeal in writing or by phone. You must begin the appeal process within 180 days of receiving a notice of denial.

To begin the appeal process, either call or write to Member Services at the toll-free number or address shown on your ID Card. The request should include:

- Your name
- Your employer's name
- A statement from your doctor or health care provider
- A copy of our notice of an adverse determination
- Your reasons for making the appeal
- Any other information you would like us to consider

You may also choose to have an authorized designee make the appeal for you. Just send us your written consent to work with this person. Your doctor may make the appeal in connection with the adverse determination for a post-service claim.

You should have a response from us within 15 days if the health care service has not yet been performed or within 30 days if you have already received the service.

If we uphold our denial after your appeal, you may request a "Level Two" appeal. Submit the request within 60 calendar days of receiving our response to the first appeal. Please note that if you decide to pursue a Level Two appeal and wait for a decision from us, you may miss the deadline to request an External Appeal from the New York State Insurance Department.

A "rush" review may be possible
If your doctor thinks you cannot wait 30 days, ask for an "expedited review." That means we will make our decision within 72 hours, or two business days from when we receive all the necessary information.

Get a review from someone outside Aetna
In some cases, you can ask for an outside review if you're not satisfied after going through our internal appeals process. Follow the instructions on our response to your appeal. You must begin the request within 45 days of receiving the final appeal response. Call Member Services to ask for an External Review Form or log on to **www.aetna.com/individuals-families-health-insurance/member-guidelines/ext_review.html.** You can also request an external review from the New York State Department of Insurance. Call **1-800-400-8882** or visit **www.ins.state.ny.us**.

Most claims are allowed to go to external review. An exception would be if you are denied because you're no longer eligible for the plan.

If your case qualifies, an Independent Review Organization (IRO) will assign it to an outside expert. The expert will be a doctor or other professional who specializes in that area or type of dispute. You should have a decision within 30 calendar days of the request.

We will follow the external reviewer's decision. We will also pay the cost of the review.

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.

You have a right to ask for the following information:

- List of the names, business addresses, and official positions of the board of directors, officers, controlling persons, owners or partners of the plan
- The most recent certified financial statements of the plan, including a balance sheet and summary of receipts and disbursements prepared by a certified public accountant
- Copy of the most recent individual, direct-pay subscriber contracts
- Information relating to consumer complaints that we have received
- Our procedures for how we protect your privacy
- The preferred drug list (or "formulary"), if any, that the plan uses plus any list of drugs that are not covered
- Written description of the organizational arrangements and ongoing procedures of the plan's quality assurance program
- Description of how decisions are made about the experimental or investigational nature of drugs, medical devices or treatments in clinical trials
- A list of which doctors are affiliated with which hospitals
- Upon written request, specific written clinical review criteria relating to a particular condition or disease and, where appropriate, other clinical information which the plan might consider in its patient management program. The plan may include with the information a description of how it will be used in the patient management process, provided, however, that to the extent such information is proprietary to the plan, the enrollee or prospective enrollee shall only use the information for the purposes of assisting the enrollee or prospective enrollee in evaluating the covered services provided by the plan. What this means is, if you want to know what we cover or do not cover for a particular condition, you can ask us and we will send you the rationale for our coverage position.
- How a doctor applies to be in the network and what we look for when making a decision
- Any other information that the law requires us to send you when you ask for it

How our members participate in driving our business
There's always at least one member on our Board of Directors. This person is an active participant in managing the operations of the company.

We often send surveys to our members asking for any ideas and comments about our business, including our policies and procedures. We also ask for member's views on the services they get from their doctors. This input helps us plan and evaluate our services, policies and procedures.

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 advance 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 advance directives:

- Durable power of attorney – name 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 advance 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 advance directive.
- Create an advance directive using computer software designed for this purpose.

Not satisfied with the how we handle advance directives? File a complaint with your Medicare State Certification Agency. Visit **www.medicare.gov** for information on specific state agencies or call **1-800-MEDICARE** (1-800-633-4227) (TTY/TDD: 1-877-486-2048).

Source: American Academy of Family Physicians. Advanced Directives and Do Not Resuscitate Orders. September 2010. Available at **http://familydoctor.org/online/famdocen/home/pat-advocacy/endoflife/003.html**. Accessed December 6, 2010.

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/individuals-families-health-insurance/member-guidelines/health-care-quality.html**. You can also call Member Services to ask for a printed copy. See "Contact Us" on page 1.

We protect your privacy

We consider your personal information to be private. Our policies help us protect your privacy. By "personal information," we mean information about your physical condition, the health care you receive and what your health care costs. Personal information does not include what is available to the public. For example, anyone can find out what your health plan covers or how it works. It also does not include summarized reports that do not identify you.

Below is a summary of our privacy policy. For a copy of our actual policy, go to **www.aetna.com.** You'll find the "Privacy Notices" link at the bottom of the page. You can also write to:

Aetna Legal Support Services Department
151 Farmington Avenue, W121
Hartford, CT 06156

Summary of the Aetna privacy policy
We have policies and procedures in place to protect your personal information from unlawful use and disclosure. We may share your information to help with your care or treatment and administer our health plans and programs. We use your information internally, share it with our affiliates, and we 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
- Third-party administrators
- Vendors
- Consultants
- Government authorities and their respective agents

These parties must also keep your information private. Doctors in the Aetna network must allow you to see your medical records within a reasonable time after you ask for them.

Some of the ways we use your personal information include:

- Paying claims
- Making decisions about what to cover
- Coordinating payments with other insurers
- Preventive health, early detection, and disease and case management

We consider these activities key for the operation of our health plans. We usually will not ask if it's okay to share your information unless the law requires us to. We will ask your permission to disclose personal information if it is for marketing purposes. Our policies include how to handle requests for your information if you are unable to give consent.

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 contractually obligated to the same.

We must comply with these laws:

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

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

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

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

When you lose your other coverage

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

When you have a new dependent

Getting married? Having a baby? A new dependent changes everything. And you can change your mind. If you chose not to enroll during the normal open enrollment period, you can enroll within 31 days after a life event. That includes marriage, birth, adoption or placement for adoption. Talk to your benefits administrator for more information, to request special enrollment or for more information.

Getting proof that you had previous coverage

Sometimes when you apply for health coverage, the insurer may ask for proof that you were covered before. This helps determine if you are eligible for their 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.

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 this 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**.