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Important information about your health benefits – Washington

For Traditional Choice® indemnity plans

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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 chose. This includes what's covered, what's not covered and what you will pay for services. Plan document names vary. They may include a Booklet-Certificate, 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.

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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 and health insurance plans are underwritten and/or administered by Aetna Life Insurance Company.

Get plan information online and by phone

If you're already enrolled in an Aetna health plan

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

1. **Log in to your secure Aetna Navigator® member website**

   You can get coverage information for your plan online. You can also get details about any programs, tools and other services that come with your plan. Just register once to create a user name and password.

   Have your Aetna ID card handy to register. Then visit **www.aetna.com** and click "Log In/Register." Follow the prompts to complete the one-time registration.

   Then, you can log in any time to:

   - Verify who's covered and what's covered
   - Access your "plan documents"
   - Track claims or view past copies of Explanation of Benefits statements
   - Learn more about and access any wellness programs that come with your plan

2. **Use your mobile device to access a streamlined version of Aetna Navigator**

   Go to your Play Store (Android) or App Store (iPhone) and search for Aetna Mobile. You can also text **APPS** to **23862** to download.

   Here's just some of what you can do from Aetna Mobile:

   - View alerts and messages
   - View your claims, coverage and benefits
   - View your ID card information
   - Contact us by phone or e-mail

3. **Call Member Services at the toll-free number on your Aetna ID card**

   As an Aetna member you can use the Aetna Voice Advantage self-service options:

   - Verify who's covered under your plan
   - Find out what's covered under your plan
   - Get an address to mail your claim and check a claim status
   - Find other ways to contact Aetna
   - Order a replacement Aetna ID card
   - Be transferred to behavioral health services

   You can also speak with a representative to:

   - Understand how your plan works or what you will pay
   - Get information about how to file a claim
   - File a complaint or appeal
   - Get copies of your plan documents
   - Connect to mental health services
   - Find specific health information
   - Learn more about our Quality Management program

Not yet a member?

For help understanding how a particular medical plan works, you should review your Summary of Benefits and Coverage document or contact your employer or benefits administrator.

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

If you require language assistance, please call the Member Services number on your Aetna ID card, and an Aetna representative will connect you with an interpreter. You can also get interpretation assistance for utilization management issues or for registering a complaint or appeal. If you're deaf or hard of hearing, use your TTY and dial **711** for the Telecommunications Relay Service. Once connected, please enter or provide the Aetna telephone number you're calling.

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

Si usted necesita asistencia lingüística, por favor llame al número de Servicios al Miembro que figura en su tarjeta de identificación de Aetna, y un representante de Aetna le conectará con un intérprete. También puede recibir asistencia de interpretación para asuntos de administración de la utilización o para registrar una queja o apelación. Si usted es sordo o tiene problemas de audición, use su TTY y marcar **711** para el Servicio de Retransmisión de Telecomunicaciones (TRS). Una vez conectado, por favor entrar o proporcionar el número de teléfono de Aetna que está llamando.

You can request the following information to help you understand your plan

Washington law requires us to provide certain information to you upon request. You can find some of this information within this document. Otherwise, if you are a member, contact Member Services at the toll-free number on your ID card. All others, contact your benefits administrator.

You may request the following information about your plan:

- A list of covered benefits, including:
  - Prescription drug benefits, if any
  - A copy of the current formulary, if any is used
  - Definitions of terms such as generic versus brand name
  - Policies on the coverage of drugs, such as how they become approved or taken off the formulary
  - How consumers may be involved in decisions about benefits
- A list of exclusions, reductions and limitations to covered benefits, and an explanation of how we determine what to cover
- A statement of how we protect your privacy
- A statement of what you pay in premiums and out of pocket when you receive covered services
- A summary explanation of how to file a complaint or to appeal a denial of a claim
- A statement about the availability of a point-of-service option, if any, and how the option operates
- A convenient means to get a list of our participating primary care and specialty care providers, including disclosure of network arrangements that restrict access to providers within the plan's network

Also, upon request, we will provide written information about any health benefits plan we offer including the following:

- Any documents, instruments or other information referred to in the medical coverage agreement
- A full description of the procedures you must follow for consulting a health care provider other than your primary care provider (for example, whether you need to get a referral) and whether your primary care provider, our medical director or anyone else must authorize the referral
- Procedures, if any, you must first follow to get prior authorization (or precertification) for health care services
- A written description of how we pay health care providers, including, but not limited to, capitation provisions, fee-for-service provisions and health care delivery efficiency provisions between Aetna and a provider or network
- Descriptions and justifications for provider compensation programs, including any incentives or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to specialists
- An annual accounting of all payments we have made that have been counted against any payment limitations, visit limitations or other overall limitations on your coverage under the plan
- A copy of the adverse benefit determinations grievance process for claim or service denial and its grievance process for dissatisfaction with care
- Our accreditation status with one or more national managed care accreditation organizations, and whether we track our health care effectiveness performance using the health employer data information set (HEDIS), whether we publicly report our HEDIS data and how interested persons can access the HEDIS data

Costs and rules for using your plan

What you pay

You will share in the cost of your health care. These are called "out-of-pocket" costs. Out-of-pocket costs vary by plan and your plan may not include all of them. Your plan documents show which amounts apply to your specific plan. Those costs may include:

- **Copay** – A set amount (for example, $25) you pay for a covered health care service. You usually pay this when you get the service. The amount can vary by the type of service. For example, you may pay a different amount to see a specialist than you would pay to see your family doctor.
- **Coinsurance** – Your share of the costs for a covered service. This is usually a percentage (for example, 20 percent) of the allowed amount for the service. For example, if the health plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20 percent would be $20. The health plan pays the rest of the allowed amount.
- **Deductible** – The amount you owe for health care services before your health plan begins to pay. For example, if your deductible is $1,000, you have to pay the first $1,000 for covered services before the plan begins to pay. You may not have to pay for some services. Other deductibles may apply at the same time:
  - **Inpatient hospital deductible** – 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 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.

How we pay your doctors and other health care providers

Doctors and hospitals set the rates to charge you. It may be higher — sometimes much higher — than what your Aetna plan "recognizes" or "allows." Your doctor may bill you for the dollar amount the plan doesn't "recognize." No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket limits. This means you are fully responsible for paying everything above the amount the plan allows for a service or procedure.

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

You can call Member Services at the toll-free number on your Aetna ID card to find out the method your plan uses to reimburse doctors and other health care providers. You can also ask for an estimate of your share of the cost for services you are planning. See "Emergency and urgent care and after hours care" to learn more.

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. Your plan documents list all the services that require this approval. Your PCP or network specialist will get this approval for you.

You do not have to get precertification for emergency services.

What we look for when reviewing a request
First, we check to see that you are still a member. And we make sure the service is considered medically necessary for your condition. We also make sure the service and place requested to perform the service are cost effective. Our decisions are based entirely on appropriateness of care and service and the existence of coverage, using nationally recognized guidelines and resources. We may suggest a different treatment or place of service that is just as effective but costs less. We also look to see if you qualify for one of our 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.

Our review process after precertification (Utilization Review/Patient Management)
We have developed a patient management program to help you access appropriate health care and maximize coverage for those health care services. In certain situations, we review your case to be sure the service or supply meets established guidelines and is a covered benefit under your plan. We call this a "utilization review."

We follow specific rules to help us make your health a top concern during our reviews

- We do not reward Aetna employees for denying coverage.
- We do not encourage denials of coverage. In fact, we train staff to focus on the risks of members not getting proper care. Where such use is appropriate, our staff uses nationally recognized guidelines and resources, such as MCG (formerly Milliman Care Guidelines) to review requests for coverage. Physician groups, such as independent practice associations, may use other resources they deem appropriate.
- We do not encourage utilization decisions that result in underutilization.

Filing claims

You can download and print a claim form at **www.aetna.com/individuals-families-health-insurance/document-library/find-document-form.html**. You can also call Member Services at the number on your ID card to ask for a form. The claim form includes complete instructions including what documentation to send with it.

We determine how and whether a claim is paid based on the terms and conditions of the health coverage plan and our internal coverage policies. See "Knowing what is covered" to learn more about coverage policies.

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.
- You do not have to get approval for emergency services.

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.

How we cover emergency care
When you receive emergency care from a doctor or hospital, you pay your cost share according to your plan. If your doctor bills you for more, you may not have to pay it. Send the bill to the address listed on your member ID card. We will resolve any payment dispute with the provider.

What's not covered

Aetna plans do not cover all health care expenses. Each plan has limitations and exclusions. You can find a complete list of these exclusions and limitations in the Booklet-Certificate.

In general, this plan does not cover charges for or related to:

- All medical and hospital services not specifically covered in, or that are limited or excluded by your plan documents
- Cosmetic surgery, including breast reduction
- Custodial care
- Dental care and dental X-rays
- Donor egg retrieval
- Durable medical equipment – unless otherwise stated as covered in What the Plan Covers section in your plan documents
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial
- Hearing aids
- High-risk home births or births in a place not licensed to perform deliveries
- Immunizations for travel or work except where medically necessary or indicated
- Implantable drugs and certain injectable drugs including injectable infertility drugs
- Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents
- Long-term rehabilitation therapy
- Non-medically necessary services or supplies
- Orthotics except diabetic orthotics
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies
- Radial keratotomy or related procedures
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling or prescription drugs
- Special-duty nursing
- Therapy or rehabilitation other than those listed as covered
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

See also "What's not covered under prescription drug benefits" on page 8 for more exclusions and limitations that may apply to your plan.

No coverage based on U.S. sanctions
If U.S. trade sanctions consider you a blocked person, the plan cannot provide benefits or coverage to you. If you travel to a country sanctioned by the United States, the plan in most cases cannot provide benefits or coverage to you. Also, if your health care provider is a blocked person or is in a sanctioned country, we cannot pay for services from that provider. For example, if you receive care while traveling in another country and the health care provider is a blocked person or is in a sanctioned country, the plan cannot pay for those services. For more information on U.S. trade sanctions, visit **www.treasury.gov/resource-center/sanctions/Pages/default.aspx**.

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 guide shows which prescription drugs are covered on a preferred basis. It also explains how we choose medications to be in the guide.

When you get a drug that is not on the preferred drug guide, your share of the cost will usually be more. Check your plan documents to see how much you will pay. You can use those drugs if your plan has an "open formulary," but you'll pay the highest copay under the plan. If your plan has a "closed formulary," those drugs are not covered.

Drug companies may give us rebates when our members buy certain drugs
We may share those rebates with your employer. Rebates usually apply to drugs on the preferred drug guide. They may also apply to drugs not in the guide. In plans where you pay a percentage of the cost, your share of the cost is based on the price of the drug before Aetna receives any rebate. Sometimes, in plans where you pay a percentage of the cost instead of a flat dollar amount, you may pay more for a drug in the preferred drug guide than for a drug not in the guide.

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 preferred drug guide
Sometimes your doctor might recommend a drug that's not in the preferred drug guide. If it is medically necessary for you to use that drug, you, 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 request an exception for some drugs that are not covered

Your plan documents might list specific drugs that are not covered. Your plan may also not cover drugs that we haven't reviewed yet. You, someone helping you or your doctor may have to get our approval (a medical exception) to use one of these drugs.

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

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

Prescription drug definitions
- Brand-Name Prescription Drug(s) – A prescription drug that is protected by trademark registration.
- Medication Formulary – Also called the Aetna "preferred drug list," the formulary is a list of prescription drugs that have been evaluated and selected by Aetna clinical pharmacists for their therapeutic equivalency and efficacy. This list includes both brand-name and generic drugs and is subject to periodic review and modification by Aetna.
- Generic Prescription Drug(s) – A prescription drug that is not protected by trademark registration but is produced and sold under the chemical formulation name.
- Prescription Drugs – Any of the following:
  - A drug, biological or compounded prescription that, by federal law, may be dispensed only by prescription and is required to be labeled "Caution: Federal law prohibits dispensing without prescription"
  - Injectable insulin
  - Disposable needles and syringes that are purchased to administer insulin
  - Disposable diabetic supplies
- Precertification Program – For certain outpatient prescription drugs, your prescribing doctor must contact us to request and obtain coverage for such drugs. Our list of drugs requiring precertification is subject to change. You can get an updated copy of the list of drugs requiring precertification by calling Member Services at the number on your Aetna ID card.
- Step-Therapy Program – A form of precertification where certain prescription drugs will be excluded from coverage, unless a first-line therapy drug(s) is used first. Our list of step-therapy drugs is subject to change. You can get an updated copy of the list of drugs subject to step therapy by calling Member Services at the number on your Aetna ID card.

What's not covered under the prescription drug benefit
All prescription drug plans contain limitations and exclusions on the type of drugs that are covered.

Depending on the plan design, the following are examples of some of the types of limitations that may apply. In general, coverage is not provided for charges related to the following:

- A device of any type unless specifically included as a prescription drug. For example, prescription contraceptive devices are covered as prescription drugs.
- Any drug entirely consumed at the time and place it is prescribed
- Less than a 30-day supply or 90-unit doses of any drug dispensed by a mail-order pharmacy
- More than a 30-day supply or 90-unit doses per prescription or refill.
- The administration or injection of any drug.
- Any refill of a drug if it is more than the number of refills specified by the prescriber. Before recognizing charges, we may require a new prescription or evidence as to need:
  - If the prescriber has not specified the number of refills
  - If the frequency or number of prescriptions or refills appears excessive under accepted medical practice standards
- Any refill of a drug dispensed more than one year after the latest prescription for it or as permitted by the law of the jurisdiction in which the drug is dispensed
- Any drug provided by or while the person is an inpatient in any health care facility; or for any drug provided on an outpatient basis in any health care facility to the extent benefits are paid for it under any other part of this plan or under any other medical or prescription drug expense benefit plan carried or sponsored by your employer
- Immunization agents
- Biological sera and blood products
- Vitamins
- Nutritional supplements
- Any fertility drugs
- A prescription drug dispensed by a mail-order pharmacy that is not a preferred pharmacy
- Over-the-counter drugs unless specifically listed as covered
- Drugs used for experimental and investigational purposes
- Performance enhancing drugs (i.e., Viagra, Cialis)

Precertification program
Your pharmacy benefits plan may include our precertification program. Precertification helps encourage the appropriate and cost-effective use of certain drugs. It is your responsibility to arrange for your health care provider to call the number on your ID card to request certification. This call must be made as soon as reasonably possible before the drug is to be dispensed.

We may ask for copies of laboratory and/or medical records. If we ask for that information, you or your doctor must provide it to certify the necessity of the drug. Refer to the precertification list in the Aetna Medication Formulary Guide to determine which prescription drugs require precertification.

The precertification list is subject to periodic review and modification by Aetna. The precertification program is based on current medical findings, manufacturer labeling, FDA guidelines and cost information. For these purposes, cost information includes any rebate arrangements between Aetna and manufacturers for the benefit of Aetna. The drugs requiring precertification are subject to change. Visit our website at **www.aetna.com** for the current precertification list. Please refer to your prescription drug rider to see if precertification applies to your plan.

To be covered, drugs that require precertification must be authorized by Aetna before they are dispensed. Coverage will not be authorized if you pay your pharmacist for a prescription and then request precertification for the drug. If your physician or pharmacist did not receive advance approval and you pay the full cost of the medication, you will not be reimbursed for the cost of the drug.

Step-therapy program
This program is a different form of precertification. Under the step-therapy program, certain drugs are not covered unless you have tried one or more "prerequisite therapy" medication(s) first. However, if it is medically necessary for you to use a step-therapy medication as initial therapy without trying a "prerequisite therapy" drug, your doctor can contact us to request coverage of the step-therapy medication as a medical exception.

Changes to the approved drug list
When can my plan change the approved drug list (formulary)? If a change occurs, will I have to pay more to use a drug I had been using?

Since we regularly evaluate both new and existing therapies, our formulary is subject to change. We encourage the use of generic drugs when appropriate. The Food and Drug Administration (FDA) has deemed that generic drugs are therapeutically equivalent to brand-name drugs. Generic drugs must contain the same active ingredients in the same amounts as their brand-name counterparts. Also, the same FDA quality and safety standards apply to generic drugs and brand-name drugs. Furthermore, generic drugs may help reduce your health care expenses. Under some Aetna prescription drug benefit plans, members pay a lower copayment if they choose generic drugs over brand-name medications. Until the (APTC) reviews a new brand-name FDA-approved drug and Aetna makes a formulary determination, it will not be listed on the formulary.

Under closed formulary plans, such drugs will require your health care provider to obtain a medical exception. For open formulary plans, the new drug will be covered at the highest copay.

During the calendar year, deletions to the formulary may occur either by a drug being removed from the marketplace by a federal directive or if an FDA-approved generic formulation of a brand-name formulary drug becomes commercially available. When a new generic drug becomes commercially available, we may remove the brand-name formulary drug from the formulary and place the generic drug on the formulary instead. For most prescription plan options, this change would mean that you would receive the generic drug at a lower copay than you previously paid for the brand-name drug. Under some plan options, you would be required to pay a higher copay to continue using the brand-name drug, and/or your provider might have to obtain a medical exception for coverage for your continued use of the brand-name drug.

Requesting coverage for excluded drugs

What should I do if I want a change from limitations, exclusions, substitutions or cost increases for a drug specified in this plan?

If you have a pharmacy benefit plan with a closed formulary and it is medically necessary for you to use a drug that is on the Drug Formulary Exclusion List, your provider (or pharmacist in the case of antibiotics and analgesics) may contact the Pharmacy Management Precertification Unit via fax at **1-800-408-2386** or by calling the unit at **1-800-414-2386** to request coverage of a drug on the Drug Formulary Exclusions List as a medical exception. If your pharmacy benefit plan includes the precertification or step-therapy program and it is medically necessary for you to use a drug on the precertification or step-therapy lists, your provider should contact us to request a medical exception. We will respond to complete exception requests within 24 hours of receipt. In urgent or emergent situations, providers may request a same-business-day response. Coverage granted as a result of a medical exception will be based on an individual case-by-case medical necessity determination, and coverage will not apply or extend to other members.

Clinical Policy Bulletins (CPB) detail general criteria used in determining medical exceptions for many drugs. CPBs are available on our website, **www.aetna.com**. You may also contact Member Services at the number on your ID card to request the CPB for a specific drug if one is available.

If we deny your provider's precertification request or medical exception request, you or your provider acting on your behalf may file an appeal (oral or written) according to the Appeal Procedures outlined in your plan documents. You may contact Member Services at the toll-free number on your ID card to file an appeal. See "What to do if you disagree with us" in this disclosure brochure, or the "Appeal Procedures" in your Booklet-Certificate for more information about the appeal process.

Out-of-pocket costs for prescription drugs

How much do I have to pay to get a prescription filled?

Your out-of-pocket costs for prescription drugs, referred to throughout this section as "copayments" will vary depending on the type of plan your employer offers. Copayments may be a specific dollar amount or a percentage of the cost of the prescription drug (coinsurance). Copayment information for the plan(s) offered by your employer is included in your pre-enrollment information.

Where to buy prescription drugs

Do I have to use certain pharmacies to pay the least out of my own pocket under this health plan? How many days' supply of most medications can I get without paying another copay or other repeating charge?

- **Retail pharmacies:** You may fill your prescriptions for up to a 30-day supply of covered medications at any licensed pharmacies. Bring your prescription and your Aetna ID card to the pharmacy and pay the full cost of the drug. You may then submit a claim form and the prescription receipt for reimbursement.
- **Network mail-order prescriptions:** Your prescription drug benefit may include mail-order delivery. You can order up to a 90-day supply of covered medications (if authorized by your physician) from a mail-order pharmacy. Medications most appropriate for mail order are those you take continuously, such as for the treatment of a chronic condition like arthritis, diabetes or heart disease. When it is time for a refill, you may call the mail-order pharmacy and place your request. For more information, please refer to your benefit plan documents or call the Member Services number on your ID card.

Other prescription drug services:

What other prescription drug services does my health plan cover?

Our prospective, concurrent and retrospective drug utilization review (DUR) programs help promote safe and appropriate dispensing.

We provide:

- Support for disease management: We have programs to help physicians identify and risk stratify plan members who have a chronic disease such as asthma, congestive heart failure, diabetes or lower back pain.
- Aetna therapeutic interchange program (ATIP): The ATIP program is an educational program designed to help control the rising costs of prescription drugs and overall medical benefit expenses. Members are not required to switch prescription drugs as a result of this educational program.
- Support for case management: Our managed pharmacy program integrates with and complements the Aetna medical plan in support of case management for members who have long-term or catastrophic illnesses.

The following information and services are available on our website at **www.aetna.com** or by calling Member Services at the number on your Aetna ID card:

- List of pharmacies that participate in the Aetna network
- Formulary, precertification and step-therapy information: Users can inquire about a specific drug using the formulary search engine this site provides.
- Claim forms: Once you are a member, you can register for and link to your secure member website to print claim forms.

Your right to safe and effective pharmacy services
State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan and what coverage limitations are in your contract. If you would like more information about the drug coverage policies under this plan, or if you have a question or concern about your pharmacy benefit, please contact us at **1-888-982-3862** or call the number on your ID card. If you would like to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract, you may contact the Washington State Office of Insurance Commissioner at **1-800-562-6900**. If you have a concern about the pharmacists or pharmacies serving you, please call the State Department of Health at **360-236-4825**.

Mental health and addiction benefits

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

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

Aetna Behavioral Health offers two screening and prevention programs for our members
- **Beginning Right® Depression Program:** Perinatal and Postpartum Depression Education, Screening and Treatment Referral
- **SASADA Program:** Substance Abuse Screening for Adolescents with Depression and/or Anxiety

Call Member Services to learn more about these programs.

Transplants and other complex conditions

Our National Medical Excellence Program® (NME) is for members who need a transplant or have a condition that can only be treated at a certain hospital. You may need to visit an Aetna Institutes of Excellence™ hospital to get coverage for the treatment. Some plans won't cover the service if you don't. We choose hospitals for the NME program based on their expertise and experience with these services. We also follow any state rules when choosing these hospitals.

Important benefits for women

Women's Health and Cancer Rights Act of 1998
Your Aetna health plan provides benefits for mastectomy and mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between breasts; prosthesis; and treatment of physical complications of all stages of mastectomy, including lymphedema. Coverage is provided in accordance with your plan design and is subject to plan limitations, copays, deductibles, coinsurance and referral requirements, if any, as outlined in your plan documents. Please contact Member Services for more information.

For more information, visit the U.S. Department of Health and Human Services website, **www.cms.gov/HealthInsReformforConsume/Downloads/WHCRA_Helpful_Tips_2010_06_14.pdf**, and the U.S. Department of Labor website, **www.dol.gov/ebsa/consumer_info_health.html**.

Knowing what is covered

You can avoid unexpected bills with a simple call to Member Services. Call the toll-free number on your ID card to find out what's covered before you receive the care.

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

We check if it's "medically necessary"

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

The product or service:

- Must meet a normal standard of care 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 Healthcare Research and Quality.
- Ask experts.
- Check how often and how successfully it has been used.

We publish our decisions in our Clinical Policy Bulletins.

We post our findings on 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.

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.

Call Member Services to file a verbal complaint or to ask for the 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.

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

If you don't agree with a denied claim, you can file an appeal.

Sometimes we receive claims for services that may not be covered by your health benefits plan. It can be confusing — even to your providers. Our job is to make coverage decisions based on your specific benefits plan. If a claim is denied, we'll send you a letter to let you know. If you don't agree, you can file an appeal.

To file an appeal, follow the directions in the letter or explanation of benefits statement that says your claim was denied. The letter also tells you what we need from you and how soon we will respond. Our appeals decisions will be based on your plan provisions and any state and federal laws or regulations that apply to your plan. You can learn more about your plan's appeal procedures from your plan documents.

- An appeal is defined as a verbal or written request by a member or a member's authorized representative, that asks for a change in the initial determination decision.
- An "adverse determination" is defined as a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan. This includes, with respect to group health plans, a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. This also includes rescissions of coverage and declination of coverage for individual plans only.

Appeal Review

- An appeal must be submitted to us within 180 days of the date we provided notice of denial. The Aetna address is on your ID card.
- We will send you an acknowledgment letter within five business days of our receipt of the appeal.
- You will be sent a response within 14 calendar days of our receipt of the appeal. The response will be based on the information provided with or after the appeal.
- If more time is needed to resolve the appeal, we will provide a written notice indicating that more time is needed, explaining why such time is needed. We will set a new date for a response. The additional time will not be extended beyond 30 days.
- In any urgent or emergency situation, you or your health care provider may call Member Services to initiate an expedited appeal. The Member Services telephone number is on your ID card. A verbal response to the appeal will be given to the health care provider within 72 hours after we receive all necessary information. We will send you written notice of the decision within two business days of our verbal response. If you are not satisfied with our response, you may request an external review.

Get a review from someone outside Aetna
You may be able to get an outside review if you're not satisfied with your appeal. You have the right to appeal any (eligibility, services not covered) decision to an independent medical review. The right to independent medical review is not restricted to denials based on medical necessity or experimental and investigative products or services.

Follow the instructions on our response to your appeal (final determination letter). Call Member Services to ask for an external review form. You can also visit **www.aetna.com**. Enter "external review" in the search bar.

You, your doctor or hospital representative must submit a request for an external review within 180 calendar days from the date you receive your final determination letter.

An independent review organization (IRO) will assign the case to a physician reviewer with appropriate expertise in the area in question. Once we receive all necessary information, the IRO will generally make a decision within 30 calendar days of the request. Expedited reviews are available when your health care provider certifies that a delay in service would jeopardize your health. Once the review is complete, the plan will abide by the decision of the external reviewer. Aetna will pay any charges by the IRO.

Call Member Services for more information
For details about your plan's appeal process, the availability of an external review process or for an external review request form, call the Member Services toll-free number listed on your ID card or visit our website at **www.aetna.com**. You may also call your state insurance or health department or consult their website for more information about state-mandated external review procedures.

Rights and responsibilities

Know your rights

You have many legal rights and responsibilities. You have the right to suggest changes in our policies and procedures. This includes our 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/individuals-families/member-rights-resources.html** to view the list. You can also call Member Services at the number on your ID card to ask for a printed copy.

Making medical decisions before your procedure

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

There are three types of advance directives:

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

You can create an advance directive in several ways:

- Ask your doctor for an advance directive form.
- Write your wishes down by yourself.
- Pick up a form at state or local offices on aging, bar associations, legal service programs or your local health department.
- Work with a lawyer to write an advance directive.
- Create an advance directive using computer software designed for this purpose.

Source: American Academy of Family Physicians. Advance Directives and Do Not Resuscitate Orders. January 2012. Available at **http://familydoctor.org/familydoctor/en/healthcare-management/end-of-life-issues/advance-directives-and-do-not-resuscitate-orders.html**. Accessed January 12, 2015.

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. The toll-free number is on your Aetna ID card.

We protect your privacy

We consider personal information to be private. Our policies protect your personal information from unlawful use. By "personal information," we mean information that can identify you as a person, as well as your financial and health information.

Personal information does not include what is available to the public. For example, anyone can access information about what the plan covers. It also does not include reports that do not identify you.

Summary of the Aetna privacy policy
When necessary for your care or treatment, the operation of our health plans or other related activities, we use personal information within our company, share it with our affiliates and may disclose it to:

- Your doctors, dentists, pharmacies, hospitals and other caregivers
- Other insurers
- Vendors
- Government departments
- Third-party administrators (TPAs) (this includes plan sponsors and/or employers)

These parties are required to keep your information private as required by law.

Some of the ways in which we may use your information include:

- Paying claims
- Making decisions about what the plan covers
- Coordination of payments with other insurers
- Quality assessment
- Activities to improve our plans
- Audits

We consider these activities key for the operation of our plans. When allowed by law, we use and disclose your personal information in the ways explained above without your permission. Our privacy notice includes a complete explanation of the ways we use and disclose your information. It also explains when we need your permission to use or disclose your information.

We are required to give you access to your information. If you think there is something wrong or missing in your personal information, you can ask that it be changed. We must complete your request within a reasonable amount of time. If we don't agree with the change, you can file an appeal.

For more information about our privacy notice or if you'd like a copy, call the toll-free number on your ID card or visit us at **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).

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.

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

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

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

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

If you need this material translated into another language, please call Member Services at 1-888-982-3862.
Si usted necesita este material en otro lenguaje, por favor llame a Servicios al Miembro al 1-888-982-3862.

www.aetna.com

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