Choose the right plan for you and your family
Aetna Leap™ plan options

www.aetna.com

62.02.300.1-NSCA (1/16)
First things first — is my doctor in the plan network?

Use the online provider search tool to find your doctor or hospital

Just visit www.aetna.com to search for doctors, hospitals and pharmacies near you.

Use network pharmacies

Your new pharmacy network doesn’t include all pharmacies. So it may be smaller than you’re used to. But it’s designed to help lower costs for drugs you need. And it includes national chains like CVS/pharmacy®, Target® and Walmart® — plus regional chains and independent pharmacies. Using network pharmacies saves you money — there is no coverage for using an out-of-network pharmacy.

We’re here to help.
Just call us at 1-844-269-3751.
### Aetna Leap plan options in Charlotte

Plans and benefits shown are the same for either network — Carolinas HealthCare or CaroMont Health

#### BRONZE LEVEL

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>In network you pay</th>
<th>In network you pay</th>
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<tr>
<td>Aetna Leap Catastrophic</td>
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<td>Aetna Leap Basic HSA</td>
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<td>Aetna Leap Basic Plus</td>
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<tr>
<td>In-network deductible and out-of-pocket maximum — individual</td>
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</tr>
<tr>
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<td>In-network deductible and out-of-pocket maximum — family</td>
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<td>Tier 1</td>
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<tr>
<td>Preventive care</td>
<td>No charge</td>
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<tr>
<td>All other services, supplies or prescriptions</td>
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<tr>
<td>Deductible applies*</td>
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**Deductible applies** means that you pay for these services until you reach your deductible. Once you reach the deductible, you have no cost sharing for any covered services — not even a copay.

#### SILVER LEVEL

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**Deductible applies** means that you pay for these services until you reach your deductible. Once you reach the deductible, you have no cost sharing for any covered services — not even a copay.

To learn more details about specific plans, including whether a plan includes out-of-network benefits, see the plan documents and the Summary of Benefits and Coverage (SBC). The link to the SBC is listed above with the benefits for each plan.

This information is a partial description of the benefits and in no way details all of the benefits, limitations or exclusions of the plan. Please refer to the individual policy, schedule of benefits and applicable riders to determine exact terms, conditions and scope of coverage, including all exclusions and limitations and defined terms.

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*Includes ophthalmologists, podiatrists, endocrinologists, dietitians, vascular specialists, psychiatrists and psychologists.
Limitations and exclusions

**Medical**
These medical plans don’t cover all health care expenses and include limitations and exclusions. Please refer to your plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. **However, your plan documents may contain exceptions to this list based on state mandates, essential health benefits or the plan design.**

**See plan documents for prescription drug coverage limitations and exclusions.**
- All medical and hospital services not specifically covered in, or that are limited or excluded by, your plan documents, including costs of services before coverage begins and after coverage ends
- Cosmetic surgery
- Custodial care
- Dental care and dental X-rays for individuals ages 19 and older
- Donor egg retrieval
- Experimental and investigational procedures (except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial)
- Eyeglass frames, nonprescription lenses and nonprescription contact lenses that are for individuals ages 19 and older or are for cosmetic purposes
- Home births
- Immunizations for travel or work
- Implantable drugs (non-contraceptive related) 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
- Non-emergency care when traveling outside the U.S.
- Nonmedically necessary services or supplies
- Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses
- Orthotics (nondiabetic related)
- Radial keratotomy or related procedures
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling
- Special or private duty nursing
- Weight-control services including surgical procedures in excess of one procedure in a two-year period, medical treatments, weight-control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications; 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

**Pediatric dental**
These medical plans don’t cover all pediatric dental care expenses and include limitations and exclusions. Please refer to your plan documents to see which services we cover. The following is a partial list of services and supplies that we generally don’t cover. **However, your plan documents may have exceptions to this list. We base these documents on state laws, essential health benefits or the plan design.**

- All pediatric dental services not specifically covered in, or that are limited or excluded by, your plan documents, including costs of services before coverage begins and after coverage ends
- Instructions for diet, plaque control and oral hygiene
- Dental services or supplies that you may primarily use to change, improve or enhance appearance
- Dental implants
- Experimental or investigational drugs, devices, treatments or procedures
- Services not necessary for the diagnosis, care or treatment of a condition
- Orthodontic treatment that isn’t medically necessary for a severe or handicapping condition
- Replacement of lost or stolen appliances
- Services and supplies provided where there is no evidence of pathology, dysfunction or disease
Language access services

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-269-3751.

Dinek’ehgo shika at’ohwol ninisingo, kwiijigo holne’ 1-844-269-3751.

如果需要中文的帮助，请拨打这个号码 1-844-269-3751.

Para obtener asistencia en Español, llame al 1-844-269-3751.

We’re here to help
To get help in another language, call 1-844-269-3751.

This material is for information only. Plan features and availability may vary by location. Rates and benefits may vary by location. 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. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna’s Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists or hospitals that are affiliated with the delivery system or physician group. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Information is believed to be accurate as of the production date.

For more information about Aetna plans, refer to www.aetna.com.

www.aetna.com

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62.02.300.1-NSC A (1/16)
Important information about your health benefits – North Carolina and South Carolina

For Aetna Open Access® Health Maintenance Organization (HMO) plans

https://my.aetna.com

01.28.336.1-NSCA (11/15)
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 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.

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 Schedule of Benefits and Certificate of Coverage and updates that come with them.

If you can’t find your plan documents, call the toll-free number on your digital member ID card to ask for a copy.

Get plan information online and by phone

Existing members

If you’re already an Aetna member, you have two convenient ways to get plan information anytime, day or night:

1. Log in to your secure member website at https://my.aetna.com

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.

Visit https://my.aetna.com and click “Log In/Register.” Follow the prompts to complete the one-time registration.

Then you can log in any time to:

• Access your digital member ID card
• Verify who’s covered and what’s covered
• Access your “plan documents”
• Track claims or view past copies of Explanation of Benefits statements
• Use the provider search tool to find in-network care
• Use our cost-of-care tools so you can know before you go
• Learn more about and access any wellness programs that come with your plan

2. Call the toll-free number on your digital member ID card

As an Aetna member you can use self-service options to:

• 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 your health plan
• 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
• Find care outside your area
• File a complaint or appeal
• Get copies of your plan documents
• Connect to behavioral health services
• Find specific health information
• Learn more about our Quality Management program

Not yet a member?

You can call us at 1-844-269-3751 if you need help understanding how a particular medical plan works.

Search your plan’s network for doctors, hospitals and other health care providers

Use the online provider search tool for the most up-to-date list of health care professionals and facilities. You can get a list of available doctors by Zip code, or enter a specific doctor’s name in the search field.

Existing members: Log in to your secure member website at https://my.aetna.com. Then, select “Doctors & Facilities” from the top menu bar.

Considering enrollment: Visit the applicable website below and answer a few questions. Then use the “Find Participating Providers” bar near the top of the screen to search for providers. You’ll need to select the plan you’re interested in from the drop-down box.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. Health benefits plans are provided by Aetna Health Inc.
North Carolina:
https://buyhealthinsurance.aetna.com/?state=NC

South Carolina:
https://buyhealthinsurance.aetna.com/?state=SC

Our online search tool is more than just a list of doctors’ names and addresses. It also includes information about:

- Where the physician attended medical school
- Board certification status
- Language spoken
- Hospital affiliations
- Gender
- Driving directions

Get a FREE printed directory

To get a free printed list of doctors and hospitals, call the toll-free number on your digital member ID card. If you’re not yet a member, call 1-844-241-0208.

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

If you require language assistance, please call the number on your digital member 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 que aparece en su tarjeta de identificación digital para el miembro, 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.

What you pay

You will share in the cost of your health care. These are called “out-of-pocket” costs. Your plan documents show the amounts that apply to your specific plan. Those costs may include:

- **Copay** — A set amount (for example, $25) you pay for covered health care service. You usually pay this when you get the service. The amount can vary by the type of service. For example, you may pay a different amount to see a specialist than you would pay to see your family doctor.

- **Deductible** — The amount you owe for health care services before your health plan begins to pay. For example, if your deductible is $1,000, you have to pay the first $1,000 for covered services before the plan begins to pay. You may not have to pay for some services.

Your costs when you go outside the network

HMOs are network-only plans. That means the plan covers health care services only when provided by a doctor who participates in the network. Not every hospital, health care facility, physician or other types of providers participate in the network. If you receive services from an out-of-network doctor or other health care provider, and it’s not an emergency, you will have to pay all of the costs for the services. See “Emergency and urgent care and care after office hours” for more.

Our network health care providers are in two groups: Tier 1 and Tier 2

Both provide high-quality care. But Tier 1 providers cost you less, every time you get care. Once you meet the Tier 1 deductible, you’re covered in full. Just as long as you continue to see Tier 1 providers. But, if you choose to see Tier 2 providers after you’ve met your Tier 1 deductible, your deductible gets bumped up. A lot. You can find the Tier deductibles listed in the plan documents.

When using the provider search tool, don’t forget to check out the providers’ network status and whether they’re Tier 1 or Tier 2 for each plan. Remember, tiering affects what you’ll pay out of pocket — like how much you spend on care and whether or not you get that great Tier 1 discount. See “Search your plan’s network for doctors, hospitals and other health care providers” in this booklet for more.

Going in network just makes sense.

- We have negotiated discounted rates for you.
- In-network doctors and hospitals won’t bill you for costs above our rates for covered services.
- You are in great hands with access to quality care from our network.
North Carolina members may be able to pay in-network cost sharing for out-of-network services

If you cannot get a medically necessary service or supply through a participating doctor or hospital without unreasonable delay, or you can’t find a participating doctor who can provide the service or supply, you can get the service or supply from a nonparticipating provider. You must precertify the service or supply first. Once precertified, we will cover the service or supply at the in-network benefit level. That means your share of the costs (copayment and/or deductible) will be at the “in-network” level. This is also true for medical emergencies. Medical emergencies do not require precertification.

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. When you receive care from a doctor in the network, your doctor gets precertification from us.

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 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.

Information about specific benefits

Emergency and urgent care and care after office hours

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

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

- Call 911 or go to the nearest emergency room. If you have time, call your doctor.
- Tell your doctor as soon as possible afterward. A friend or family member may call on your behalf.
- You do not have to get approval for emergency services.

Note: This plan only covers in-network care

This plan pays only for care you get from providers in the plan’s network. If you see an out-of-network provider and it’s not an emergency, you’ll have to pay the full cost yourself.

Emergency care is covered

Sometimes, you don’t have a choice about where you go for care, like in an emergency. When you need emergency care, we’ll treat it like you got the care in-network, even if you received it from an out-of-network provider. Emergency care is subject to your deductible. This means if you’ve already met your deductible, there’s no charge to you.

Also, we may pay less than what an out-of-network provider charges. Don’t worry, for an emergency situation, you don’t have to pay it. If
the provider bills you for the rest of the cost, just call us at the toll-free number on your digital member ID card and we’ll take care of it.

See your plan documents and the “No coverage based on U.S. sanctions” section in this booklet for more information.

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 https://my.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
When your doctor prescribes you a drug, then it’s time to use your pharmacy coverage. Use it well, and it can save you money. Here’s how:

You have coverage when you use a network
There is no coverage when you use an out-of-network pharmacy. The pharmacy network may change from time to time. Your secure member website will have the most up-to-date information.

Find a network pharmacy near you online
Before you fill a prescription, go to your secure member website. There you can find network pharmacies near you. Browse our directory, or you can look them up just like you would a doctor or hospital. See “Search your plan’s network for doctors, hospitals and other health care providers” in this booklet for more.

You can look up your drugs and know the costs ahead of time on your secure member website
Just click on “Check Drug Cost.” You’ll find your cost for each drug by pharmacy. You can also compare the cost at a local pharmacy with your cost for mail order to see how much you can save.

Some plans encourage generic drugs over brand-name drugs
Many brand-name drugs have generic versions with the same active ingredients. Or there may be a different generic drug that can treat your condition. Generic drugs are as safe and effective as their brand-name versions. For certain drugs, you must get the generic. 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 Leap Drug Guide (also known as a “formulary”). This guide shows which prescription drugs are covered under your plan. It also explains how we choose drugs to be in the guide.

When you get a drug that is not covered under your plan, your share of the cost will usually be more. Check your plan documents to see how much you will pay.

Get convenient refills by mail order
Mail-order and specialty drug services are from pharmacies that Aetna owns. Aetna Rx Home Delivery and Aetna Specialty Pharmacy, are included in your network and provide convenient options for filling medicine you take every day or specialty medicines that treat complex conditions.

You may have to get approval before some drugs covered
Sometimes your doctor might recommend a drug that’s not covered under your plan. If it is medically necessary for you to use that drug, you, someone helping you or your doctor can ask us to make an exception. Your pharmacist can also ask for an exception for antibiotics and pain medicines. Check your plan documents for details.

You may have to try one drug before you can try another
“Step-therapy” means you may have to try one or more less expensive or more common drugs before a drug on the step-therapy list will be covered. Your doctor might want you to skip one of these drugs for medical reasons. If so, you, your doctor can ask for an exception through the precertification process.

Some drugs are not covered at all
Prescription drug plans do not cover drugs that don’t need a prescription. There may be some prescription drugs that are not covered either. These drugs are not covered under your plan because there are similar products covered on your formulary. You cannot precertify these drugs.

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

Get a copy of the drug guide
You can find the Leap Drug Guide on your secure member website. Or, you can call the toll-free number on your member ID card to ask for a printed copy. We frequently add new drugs to the guide. Look online or call the toll-free number on your member ID card for the latest updates.
Mental health and addiction benefits

You must use therapists and other mental health professionals who are in the Aetna network. Here’s how to get inpatient and outpatient services, partial hospitalization and other mental health services:

- Call 911 if it’s an emergency.
- Call the toll-free # on your digital member ID card.

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 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 and referral requirements, if any, as outlined in your plan documents. Please call the toll-free number on your member ID card for more information.


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.

Knowing what is covered

Avoid unexpected bills. Check your plan documents to see what’s covered before you get health care. Can’t find your plan documents? Call the toll-free number on your digital member ID card to ask a specific question or have a copy mailed to you.

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

We check if it’s “medically necessary”

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

The product or service:

- Must meet a normal standard for doctors
- Must be the right type in the right amount for the right length of time and for the right body part
- Must be known to help the particular symptom
- Cannot be for the member’s or the doctor’s convenience
- Cannot cost more than another service or product that is just as effective

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

If we deny coverage, we’ll send you and your doctor a letter. The letter will explain how to appeal the denial. You have the same right to appeal if a physician’s group denied coverage. You can call the toll-free number on your member ID card to ask for a free copy of the materials we use to make coverage decisions. Doctors can write or call our Patient Management department with questions. Contact us either online or at the phone number on your member 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 https://my.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 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 https://my.aetna.com. Enter “Clinical Policy Bulletin” in the search bar. No Internet? Call us at the toll-free number on your digital member 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 how we do business.

You can designate a representative to participate in the complaint or grievance process. All disputes involving denial of payment for a health care service will be made by qualified personnel with experience in the same or similar scope of practice.

Call the toll-free number on your member ID card to file a verbal complaint or to ask for the address to mail a written complaint. You can also e-mail us through your secure member website. See “Get plan information online and by phone” for more information.

If you’re not satisfied after talking to a health plan representative, you can ask us to send your issue to the appropriate complaint department.

If you don’t agree with a decision related to a denied claim, you can file an appeal. To file an appeal, follow the directions in the letter or explanation of benefits statement that explains that your claim was denied. The letter will also include information about the basis for the denial, what we need from you if you wish to appeal the decision and how soon we will respond to your appeal.

Get a review from someone outside Aetna

If the denial is based on a medical judgment, you may be able to get an outside review if you’re not satisfied with your appeal (in most cases you will need to finish all of your internal appeals first). Follow the instructions on our response to your appeal. Call the toll-free number on your member ID card to ask for an external review form. You can also visit https://my.aetna.com. Enter “external review” into the search bar.

An independent review organization (IRO) will assign your case to one of their experts. The expert will be a doctor or other professional who specializes in that area or type of appeal. You should have a decision within 45 calendar days of the request. The outside reviewer’s decision is final and binding; we will follow the outside reviewer’s decision and you will not have to pay anything unless there was a filing fee.

A “rush” review may be possible

If your doctor thinks you cannot wait 45 days, ask for an “expedited review.” That means we will make our decision as soon as possible.
Member rights & responsibilities

Know your rights as a member

You have many legal rights as a member of a health plan. You also have many responsibilities. You have the right to suggest changes in our policies and procedures. This includes our member rights and responsibilities.

Some of your rights are below. We also publish a list of rights and responsibilities on our website. Visit https://my.aetna.com and enter “rights and resources” into the search bar to view the list. You can also call the number on your digital member ID card to request a printed copy or for more information.

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** — 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 advance directive form.
- Write your wishes down by yourself.
- Pick up a form at state or local offices on aging, 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.


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 https://my.aetna.com. Enter “commitment to quality” in the search bar. You can also call the toll-free number on your digital member ID card to ask for a printed copy.

**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)

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 digital member ID card or visit us at https://my.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. This includes enrolling your spouse or children and other dependents. If that happens, you must apply within 31 days after your coverage ends.

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
For more information or to request special enrollment, you can call the toll-free number on your digital member ID card. If you are not a member yet, you can call 1-844-269-3751.
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 listing of health plans and their NCQA status can be found on the NCQA website located at http://reportcard.ncqa.org.

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

1) **Health Insurance Plans** — for HMO and PPO health plans 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 drop down menu for **Managed Behavioral Healthcare Organizations** — for behavioral health accreditation and **Credentials Verifications Organizations** — for credentialing certification.

If you need this material translated into another language, please call 1-844-241-0208.
Si usted necesita este material en otro lenguaje, por favor llame al 1-844-241-0208.

https://my.aetna.com

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01.28.336.1-NCA (11/15)