

Important information about your health benefits

For Open Choice PPO plans and these Aetna Open Access® plans: Open Access HMO, Aetna Choice POS, Open Access Managed Choice, Health Network Only, and Health Network Option.

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.

Warning: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

Not all of the information in this booklet applies to your specific plan

Most of the information in this booklet applies to all plans. But some does not. For example, not all plans have deductibles or prescription drug benefits. Information about those topics will only apply if your plan includes those provisions.

State-specific information throughout this booklet does not apply to all plans. To be sure, review your plan documents, ask your benefits administrator or call Aetna Member Services.

Where to find information about your specific plan

Your plan documents list all the details for your plan, such as what's covered, what's not covered and the specific amounts 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.

Table of Contents

Understanding your plan of benefits	1
Getting help	2
Contact us	2
Help for those who speak another language and for the hearing impaired.....	2
Search our network for doctors, hospitals and other health care providers	2
Costs and rules for using your plan	3
What you pay.....	3
Your costs when you go outside the network.....	3
Precertification: Getting approvals for services.....	4
You never need referrals with open access plans.....	4
Filing claims in Oklahoma.....	5
Information about specific benefits	5
Emergency and urgent care and care after office hours.....	5
Prescription drug benefit	5
Behavioral health and substance abuse benefits.....	6
Breast reconstruction benefits	7
Transplants and other complex conditions	7
Other state benefits.....	7
Knowing what is covered	8
We check if it's "medically necessary"	8
We study the latest medical technology	8
We post our findings on www.aetna.com	8
We can help when more serious care is suitable.....	8
What to do if you disagree with us	9
Complaints, appeals and external review.....	9
Member rights and responsibilities	9
Know your rights as a member	9
Making medical decisions before your procedure	9
Learn about our quality management programs.....	10
We protect your privacy	10
Anyone can get health care.....	10
How we use information about your race, ethnicity and the language you speak	10
Your rights to enroll later if you decide not to enroll now.....	10
Consumer Choice Option for Georgia members.....	11
Nondiscrimination for genetic testing	11
Other rights by state	11

* 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, underwritten or administered by Aetna Health Inc., Aetna Health of Illinois Inc., Aetna Health of the Carolinas Inc., Aetna Health Insurance Company and/or Aetna Life Insurance Company.

Have a Student Plan?

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

Getting help

Contact us

Member Services can help with your questions. To contact Member Services, call the toll-free number on your ID card. You can also send Member Services an e-mail. Just go to your secure Aetna Navigator® member website at www.aetna.com. Click on "Contact Us" after you log on.

Member Services can help you:

- 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 (if included in your plan)
- Find specific health information
- Learn more about our Quality Management program
- And more

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

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

Language hotline – 1-888-982-3862 (140 languages are available. You must ask for an interpreter.)

TDD 1-800-628-3323 (hearing impaired only)

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

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

Línea directa: 1-888-982-3862 (Tenemos 140 idiomas disponibles. Debe pedir un intérprete.)

TDD 1-800-628-3323 (sólo para personas con impedimentos auditivos)

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

It's important to know who is in our network. Some plans only let you go in network. Some plans let you go out of network. But, most of the time you pay less when you visit doctors, hospitals, labs and other health care providers who are in our network.

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

- Log on to your secure Aetna Navigator member website at www.aetna.com. Follow the path to find a doctor and enter your doctor's name in the search field.
- Call us at the toll-free number on your Aetna ID card. If you don't have your card you can call us at 1-888-87-AETNA (1-888-872-3862).

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

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

Not every health care provider who participates in the Aetna network will be accepting new patients. Although we have identified those providers who were not accepting patients as known to us at the time the listing was created, the status of the physician's practice may have changed. For the most current information about the status of any physician's practice, please contact either the selected physician or call Member Services at the toll-free number listed on your ID card.

If you live in **Georgia**, you can call toll-free at **1-800-223-6857** to confirm that the preferred provider in question is in the network and/or accepting new patients.

Michigan members may contact the Michigan Office of Financial and Insurance Services at **517-373-0220** to:

- Verify participating providers' license
- Access information on formal complaints and disciplinary actions filed or taken against a health care provider in the immediate preceding three years.

For more information on your health plan, call Member Services at 1-800-208-8755 or refer to your plan documents.

A provider's right to join the network – Kentucky

Any health care provider who meets our enrollment criteria and who is willing to meet the terms and conditions for participation has a right to become a participating provider in our network.

Customary waiting times – Kentucky

- Regular or routine care appointments – Within seven days
- Urgent care appointments – Same day or within 24 hours
- After-hours care – Each primary care physician must have a reliable answering service or machine with a beeper or paging system available twenty-four (24) hours a day, seven(7) days a week. A recorded message or answering service that refers members to emergency rooms is not acceptable.

Some doctors are not in the Aetna network even if they work in a network hospital

Louisiana notice: *"Health care services may be provided to you at a network health care facility by facility-based physicians who are not in your health plan. You may be responsible for payment of all or part of the fees for those out-of-network services, in addition to applicable amounts due for copayments, coinsurance, deductibles, and noncovered services."*

Specific information about in-network and out-of-network facility-based physicians can be found at the website address of your health plan or by calling the customer service telephone number of your health plan"

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. Your plan documents show the amounts that apply to your specific plan. Those costs may include:

- Copay – A fixed amount (for example, \$15) you pay for a covered health care service. You usually pay this when you receive the service. The amount can vary by the type of service. For example, the copay for your primary doctor's office visit may be different than a specialist's office visit.
- Coinsurance – Your share of the costs of a covered service. Coinsurance is calculated as a percent (for example, 20%) of the allowed amount for the service. For example, if the health plan's allowed amount for an office visit is \$100 and you've met your deductible, your coinsurance payment of 20% would be \$20. The health plan pays the rest of the allowed amount.
- Deductible – Some plans include a deductible. This is the amount you owe for health care services before your health plan begins to pay. For example, if your deductible is \$1,000, your plan won't pay anything until you have paid \$1,000 for any covered health care

services that are subject to the deductible. The deductible may not apply to some preventive services, such as an annual physical or mammogram. Other deductibles may apply at the same time:

- Inpatient Hospital Deductible – This deductible applies when you are a patient in a hospital.
- Emergency Room Deductible – This is the amount you pay when you go to the emergency room. If you are admitted to the hospital within 24 hours, you won't have to pay it.

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

Your costs when you go outside the network

Network-only plans

Open Access HMO and Health Network Only plans are network-only plans. That means the plan covers health care services only when provided by a doctor who participates in the Aetna network. If you receive services from an out-of-network doctor or other health care provider, you will have to pay all of the costs for the services.

Plans that cover out-of-network services

With Open Choice, Health Network Option, Open Access Managed Choice and Aetna Choice POS plan, you may choose a doctor in our network. You may choose to visit an out-of-network doctor.

We cover the cost of care based on if the provider (such as a doctor or hospital), is "in network" or "out of network." We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this care. We will use examples for a doctor.

If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor.

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

“Out of network” means that we do not have a contract for discounted rates with that doctor. We don’t know exactly what an out-of-network doctor will charge you. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor’s bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor.

Your out-of-network doctor or hospital sets the rate to charge you. It may be higher — sometimes much higher — than what your Aetna plan “recognizes” or “allows.” Your doctor may bill you for the dollar amount that Aetna doesn’t “recognize.” You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the “recognized charge” counts toward your deductible or out-of-pocket limits.

This means that you are fully responsible for paying everything above the amount that Aetna allows for a service or procedure.

How we pay doctors who are not in our network

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

This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. See “Emergency and urgent care and care after office hours” for more.

Going in network just makes sense!

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

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

Precertification: Getting approvals for services

Sometimes we will pay for care only if we have given an approval before you get it. We call that “precertification.” Precertification is usually limited to more serious care like surgery or being admitted to a hospital or hospital or skilled nursing facility. When you get care from a doctor in the Aetna network, your doctor takes care of precertification. But if you get your care outside our network, you must call us for precertification when that’s required. Your plan documents list all the services that require you to get the precertification. If you don’t, you will have to pay for all or a larger share of the cost of the service. Even with precertification, if you receive services from an out-of-network provider, you will usually pay more.

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

Precertification is not required for emergency services.

What we look for when reviewing a precertification request

First, we check to see that you are still a member. And we make sure the service is considered medically necessary for your condition. We also check that the service and place requested to perform the service is cost effective. If we know of a treatment or place of service that is just as effective but costs less, we may talk to you or your doctor about it. We also look to see if you qualify for one of our case management programs. If so, one of our nurses may call to tell you about it and help you understand your upcoming procedure.

Precertification does not, however, verify if you have reached any plan dollar limits or visit maximums for the service requested. That means precertification is not a guarantee that the service will be covered.

You never need referrals with open access plans

As an Aetna Open Access plan member, you never need a referral from your regular doctor to see a specialist. You also do not need to select a primary care provider (PCP), but we encourage you to do so to help you navigate the health care system. Regardless, some states require us to tell you about certain open access benefits. Be assured that all of your benefits are “open access,” including the following:

Direct Access Chiropractor and Podiatrist

In **Florida**, you have direct access to a participating primary care chiropractic and podiatric provider of your choice and do not need a referral from your PCP to access these benefits covered under your health benefits plan.

Direct Access Dermatologist

In **Florida**, you have direct access to a participating primary care dermatologist provider of your choice and do not need a referral from your PCP to access these benefits covered under your health benefits plan.

Direct access to participating primary chiropractic providers

If you live in **Kentucky**, you have direct access to the participating primary chiropractic provider of your choice. You do not need a referral from your PCP to access chiropractic benefits covered under your benefits plan.

Routine Vision Care

In **Tennessee**, you are covered for routine vision exams from participating providers without a referral from your PCP. Copayments may apply. For routine eye exams, you can visit a participating optometrist or ophthalmologist without a referral, once every 12 months. A contact lens fitting exam is not covered.

Other benefits for members in Georgia

Female members have direct access to the participating primary Ob/Gyn provider of their choice and do not need a referral from their PCP for a routine well-woman exam, including a Pap smear when appropriate and an unlimited number of visits for gynecologic problems and follow-up care.

You have direct access to the participating dermatologist provider of your choice and do not need a referral from your primary care physician(s) to access dermatologic benefits covered under your health plan. A summary of any agreement or contract between Aetna and any health care provider will be made available upon request by calling the Member Services telephone number listed on your ID card. The summary will not include financial agreements as to actual rates, reimbursements, charges, or fees negotiated by Aetna and the provider. The summary will include a category or type of compensation paid by Aetna to each class of health care provider under contract with Aetna.

Filing claims in Oklahoma

Aetna participating doctors and other health care providers in the Aetna network will file claims for you. Out-of-network doctors generally do not. If you need to file a claim, 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.

Aetna determines how and whether a claim is paid based on the terms and conditions of the health coverage plan and our internal coverage policies. See section "Knowing what is covered" on page 8 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. If a delay would not risk your health, call your doctor or PCP.

- Tell your doctor or PCP as soon as possible afterward. A friend or family member may call on your behalf.
- Emergency care services do not require precertification.

In **Kentucky**, the definition for **Emergency Medical Condition** is a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson would reasonably have cause to believe constitutes a condition that the absence of immediate medical attention could reasonably be expected to result in: placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, a situation in which there is inadequate time to effect a safe transfer to another hospital before delivery; or a situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.

How we cover out-of-network emergency care

You are covered for emergency and urgently needed care. You have this coverage while you are traveling or if you are near your home. That includes students who are away at school. When you need care right away, go to any doctor, walk-in clinic, urgent care center or emergency room.

We'll review the information when the claim comes in. If we think the situation was not urgent, we might ask you for more information and may send you a form to fill out. Please complete the form, or call Member Services to give us the information over the phone.

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

After-hours care – available 24/7

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

Prescription drug benefit

Some plans encourage generic drugs over brand-name drugs

A generic drug is the same as a brand-name drug in dose, use and form. They are FDA approved and safe to use.

Generic drugs usually sell for less; so many plans give you incentives to use generics. That doesn't mean you can't use a brand-name drug, but you'll pay more for them. You'll not only pay your normal share of the cost, you'll also pay the difference in the two prices.

We may also encourage you to use certain drugs

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

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

Drug Manufacturer Rebates

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

In plans where you pay a percent of the cost instead of a flat dollar amount, you may pay more for a drug on the Preferred Drug List than for a drug not on the list.

Mail-order and specialty-drug services are from Aetna-owned pharmacies

Aetna Rx Home Delivery and Aetna Specialty Pharmacy are pharmacies that Aetna owns. These pharmacies are for-profit entities.

You might not have to stick to the list

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

You may have to try one drug before you can try another

Step therapy means you have to try one or more "prerequisite" drugs before a "step-therapy" drug will be covered. The preferred drug list includes step-therapy drugs. Your doctor might want you to skip one of these drugs for medical reasons. If so, you or your doctor (or pharmacist in the case of antibiotics and pain medicines) can ask for a medical exception.

Some drugs are not covered at all

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

New drugs may not be covered

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

Get a copy of the preferred drug list

The Aetna Preferred Drug Guide is posted to our website at www.aetna.com/formulary/. If you don't use the Internet, you can ask for a printed copy. Just call Member Services at the toll-free number on your Aetna ID card. We are constantly adding new drugs to the list. Look online or call Member Services for the latest updates.

Have questions? Get answers!

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

Behavioral health and substance abuse benefits

With Open Access HMO and Health Network Only plans, you must use behavioral health professionals who are in the Aetna network. With all other plans, you can use any licensed behavior health provider, in or out of the Aetna network.

Here's how to get behavioral health services

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

If you access a behavioral health professional who is not in the Aetna network, you are responsible for getting any required precertification. You can access most outpatient therapy services without precertification. However, you should first consult Member Services to confirm that any such outpatient therapy services do not require precertification.

Read about behavioral health provider safety

We want you to feel good about using the Aetna network for behavioral health services.

Visit www.aetna.com/docfind and click the "Get info on Patient Safety and Quality" link. No Internet? Call Member Services instead. Use the toll-free number on your Aetna ID card to ask for a printed copy.

Behavioral health programs to help prevent depression

Aetna Behavioral Health offers two prevention programs for our members:

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

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

Breast reconstruction benefits

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

- (1) all stages of reconstruction of the breast on which a mastectomy has been performed;
- (2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
- (3) prostheses; and
- (4) treatment of physical complications of all stages of mastectomy, including lymph edemas.

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

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

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

Oklahoma Breast Cancer Patient Protection Act

The Oklahoma Breast Cancer Patient Protection Act requires Aetna health plans to provide the following benefits:

- A member receiving benefits for a medically necessary mastectomy will be provided coverage for not less than 48 hours of inpatient care following the mastectomy, unless the attending physician in consultation with the member determines that a shorter period of hospital stay is appropriate.
- A member receiving benefits for a lymph node dissection for the treatment of breast cancer will be provided coverage for not less than 24 hours of inpatient care following the lymph node dissection, unless the attending physician in consultation with the member determines that a shorter hospital stay is appropriate.

- A member receiving benefits for a medically necessary partial or total mastectomy will be provided coverage for reconstructive breast surgery performed as a result of the mastectomy, except as prohibited by federal laws or regulations pertaining to Medicaid. When such reconstructive surgery is performed on a diseased breast, coverage will be provided for all stages of reconstructive surgery performed on a nondiseased breast to establish symmetry with the diseased breast, provided that the reconstructive surgery and any adjustments made to the nondiseased breast must occur within 24 months of reconstruction of the diseased breast.

Transplants and other complex conditions

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

Colorado mandated benefits

In Colorado, small group plans (groups with less than 50 members) must cover health services required by the state, including: coverage for newborn, maternity, pregnancy, childbirth, complications from pregnancy and childbirth, therapies for congenital defects and birth abnormalities, low-dose mammography, mental illness, biologically based mental illness, the availability of alcoholism treatment, the availability of hospice care, prostate cancer screening, child health supervision, hospitalization and general anesthesia for dental procedures for dependent children, diabetes, prosthetic devices, early intervention services for certain children, colorectal screening, cervical cancer vaccinations, and certain routine care during participation in a clinical trial.

Religious exemption for members in Connecticut

As permitted under Connecticut law, an insurer may issue to a religious employer a policy that excludes coverage for infertility treatment that is contrary to the religious employer's beliefs.

Some of these treatments may include:

- Ovulation induction (OI)
- Intrauterine insemination
- In-vitro fertilization (IVF)
- Embryo transfer
- Gamete intra-fallopian transfer (GIFT)
- Zygote intra-fallopian transfer (ZIFT)
- Low tubal ovum transfer
- Uterine embryo lavage

Religious exemption for members in West Virginia

West Virginia Legislation mandates that group insurance policies and contracts that provide coverage for prescription drugs must include a rider providing coverage for contraceptive drugs and devices that are approved by the FDA or generics approved as substitutes by the FDA. However, "Religious Employers," as defined in the law, may elect not to include this coverage under their policy or contract. If a religious employer elects not to provide coverage for contraceptives, each member/enrollee covered under the contract is eligible to obtain a contraceptive rider directly from Aetna. Please refer to your plan administrator for specifics regarding your benefits.

Knowing what is covered

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

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

Only medical professionals can deny coverage if the reason is medical necessity. We do not give financial incentives or otherwise to Aetna employees for denying coverage.

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

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 for medical necessity. You can call Member Services to ask for a free copy of the criteria we use to make coverage decisions. Or visit www.aetna.com/about/cov_det_policies.html to read our policies.

Doctors can write or call our Patient Management department with questions. Contact Member Services either online or at the phone number on your Aetna ID card for the appropriate address and phone number.

We study the latest medical technology

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

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

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

We publish our decisions in our Clinical Policy Bulletins.

We post our findings on www.aetna.com

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

CPBs tell if we view a product or service as medically necessary. They also help us decide whether to approve a coverage request. But your plan may not cover everything that our CPBs say is medically necessary. Each plan is different, so check your plan documents.

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

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

We can help when more serious care is suitable

In certain cases, we review a request for coverage to be sure the service or supply is consistent with established guidelines. Then we follow up. We call this "utilization management review."

It's a three step process:

First, we begin this process if your hospital stay lasts longer than what was approved. We verify that it is necessary for you to still be in the hospital. We look at the level and quality of care you are getting. (In South Dakota, "concurrent review" is defined as a utilization review conducted during a patient's hospital stay or course of treatment in a facility or other inpatient or outpatient health care setting.)

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

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

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

- Aetna employees are not compensated based on denials of coverage.
- We do not encourage denials of coverage. In fact, our utilization review staff is trained to focus on the risks of members not adequately using certain services.

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

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 appropriate address to mail a written complaint. The phone number is on your Aetna ID card. You can also e-mail Member Services through the secure member website.

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

If you don't agree with a denied claim, 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 also tells you what we need from you and how soon we will respond.

Get a review from someone outside Aetna

In some cases, you can ask for an outside review if you're not satisfied after going through our internal appeals process. Follow the instructions on our response to your appeal. Call Member Services to ask for an External Review Form or log on to www.aetna.com/individuals-families-health-insurance/member-guidelines/ext_review.html.

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

If your case qualifies, an Independent Review Organization (IRO) will assign it to an outside expert. The expert will be a doctor or other professional who specializes in that area or type of dispute. You should have a decision within 45 calendar days of the request.

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

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 more quickly.

Member rights & responsibilities

Know your rights as a member

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

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

Making medical decisions before your procedure

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

There are three types of advanced directives:

- Durable power of attorney – 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 advanced directive in several ways:

- Ask your doctor for an advanced directive form.
- Pick up a form at state or local offices on aging, bar associations, legal service programs or your local health department.
- Work with a lawyer to write an advanced directive.

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

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

Learn about our quality management programs

We make sure your doctor provides quality care for you and your family. To learn more about these programs, go to our website at www.aetna.com/individuals-families-health-insurance/member-guidelines/health-care-quality.html. You can also call Member Services to ask for a printed copy. See "Contact Us" on page 1.

We protect your privacy

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

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

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

Summary of the Aetna privacy policy

We have policies and procedures in place to protect your personal information from unlawful use and disclosure. We may share your information to help with your care or treatment and administer our health plans and programs. We use your information internally, share it with our affiliates, and we may disclose it to:

- Your doctors, dentists, pharmacies, hospitals and other caregivers
- Those who pay for your health care services. That can include health care provider organizations and employers who fund their own health plans or who share the costs.
- Other insurers
- Third-party administrators
- Vendors
- Consultants
- Government authorities and their respective agents

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

Some of the ways we use your personal information include:

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

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

Anyone can get health care

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

We must comply with these laws:

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

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

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

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

When you lose your other coverage

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

When you have a new dependent

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

Getting proof that you had previous coverage

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

Consumer Choice Option for Georgia members

The Consumer Choice Option is available for Georgia residents enrolled in certain Aetna managed care plans. Under this benefits option, with certain restrictions required by law and an additional monthly premium cost, members of certain Aetna managed care plans may nominate an out-of-network provider to provide covered services for themselves and their covered family members. Your benefits and any applicable copayments will be the same as for in-network providers. The out-of-network provider must agree to accept the Aetna compensation, to adhere to the plan's quality assurance requirements, and to meet all other reasonable criteria required by the plan of its in-network participating providers. It is possible the provider you nominate will not agree to participate.

Nondiscrimination for genetic testing

Aetna will not in any way use the results of genetic testing to discriminate against applicants or enrollees.

Other rights by state

Colorado

Small employers purchasing any health benefit plan other than the Colorado Basic Limited Mandate Health Benefit Plan must pay for all of the mandated benefits pursuant to section 10-16-104, C.R.S. The premium for this plan includes the cost of these mandated benefits, specifically: coverages for newborn, maternity, pregnancy, childbirth, complications from pregnancy and childbirth, therapies for congenital defects and birth abnormalities, low-dose mammography, mental illness, biologically-based mental illness, the availability of alcoholism treatment, the availability of hospice care, prostate cancer screening, child health supervision, hospitalization and general anesthesia for dental procedures for dependent children, diabetes,

prosthetic devices, early intervention services for certain children, colorectal screening, cervical cancer vaccinations, and certain routine care during participation in a clinical trial.

Hawaii – Informed Consent

You have the right to be fully informed before making any decision about any treatment, benefit or nontreatment.

Your provider will:

- Discuss all treatment options, including the option of no treatment at all
- Ensure that persons with disabilities have an effective means of communication with the provider and other members of the managed care plan
- Discuss all risks, benefits, and consequences of treatment and nontreatment

Your provider will also discuss with you and your immediate family both living wills and durable powers of attorney in relation to medical treatment.

Hawaii State Insurance Department

You may contact the Hawaii Insurance Division and the Office of Consumer Complaints at 1-808-586-2790.

Illinois

Illinois law requires health plans to provide the following information each year to enrollees and to prospective enrollees upon request:

- A complete list of participating health care providers in the health care plan's service area
- A description of the following terms of coverage:
 1. The service area
 2. The covered benefits and services with all exclusions, exceptions and limitations
 3. The precertification and other utilization review procedures and requirements
 4. A description of the process for the selection of a PCP, any limitation on access to specialists, and the plan's standing referral policy
 5. The emergency coverage and benefits, including any restrictions on emergency care services
 6. The out-of-area coverage and benefits, if any
 7. The enrollee's financial responsibility for copayments, deductibles, premiums, and any other out-of-pocket expenses
 8. The provisions for continuity of treatment in the event a health care provider's participation terminates during the course of an enrollee's treatment by the provider
 9. The appeals process, forms, and time frames for health care services appeals, complaints, and external independent reviews, administrative complaints, and utilization review complaints, including a phone number to call to receive more information from the health care plan concerning the appeals process

10. A statement of all basic health care services and all specific benefits and services to be provided to enrollees by a state law or administrative rule
 - A description of the financial relationship between the health plan and any health care provider, including, if requested, the percentage of copayments, deductibles, and total premiums spent on health care related expenses and the percentage of copayments, deductibles and total premiums spent on other expenses, including administrative expenses.

Kansas

Kansas law permits you to have the following information upon request:

1. A complete description of the health care services, items and other benefits to which the insured is entitled in the particular health plan that is covering or being offered to such person
2. A description of any limitations, exceptions or exclusions to coverage in the health benefits plan, including prior authorization policies, restricted drug formularies or other provisions that restrict access to covered services or items by the insured
3. A listing of the plan's participating providers, their business addresses and telephone numbers, their availability, and any limitation on an insured's choice of provider
4. Notification in advance of any changes in the health benefit plan that either reduces the coverage or benefits or increases the cost to such person
5. A description of the grievance and appeal procedures available under the health benefits plan and an insured's rights regarding termination, disenrollment, nonrenewal or cancellation of coverage

If you are a member, contact Member Services by calling the toll-free number on your ID card to request additional information. If you are not yet an Aetna member, contact your plan administrator.

Kentucky

Upon enrollment and upon request, we will provide you with the following information: (1) a current participating provider directory with information on access to primary care providers and available providers; (2) general information about the type of financial incentives between participating providers under contract with the insurer;

and (3) our standard customary waiting times for appointments for urgent and routine care. Additionally, upon request, we will make available information about the provider network, including hospital affiliations and whether a particular network provider is board certified and whether a provider is currently accepting new patients. Members may contact Member Services at the toll-free number on their ID card for more information; all others contact your benefits administrator.

Kentucky – Customary Waiting Times

- Regular or routine care appointments – Within seven days
- Urgent care appointments – Same day or within 24 hours
- After-hours care – Each primary care physician must have a reliable answering service or machine with a beeper or paging system available twenty-four (24) hours a day, seven(7) days a week. A recorded message or answering service that refers members to emergency rooms is not acceptable.

Louisiana – Genetic Testing

Aetna will not in any way use the results of genetic testing to discriminate against applicants or enrollees.

North Carolina

Procedures and medically based criteria for determining whether a specified procedure, test or treatment is experimental, are available upon request.

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

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

Providers, in all settings, achieve recognition by submitting data that demonstrates they are providing quality care. The program constantly assesses key measures that were carefully defined and tested for their relationship to improved care; therefore, NCQA provider recognition is subject to change. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice.

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