

# Important Disclosure Information Washington

For Managed Choice<sup>®</sup>, Elect Choice<sup>®</sup>, Open Choice<sup>®</sup> and Aetna Open Access<sup>®</sup> Plans.

**State mandates do not apply to self-funded plans governed by ERISA. If you are unsure if your plan is self-funded and/or governed by ERISA, see your benefits administrator.**

This disclosure brochure is intended to provide information to employer groups who are considering purchasing a health benefits plan and to their employees who are considering enrolling in the Aetna plan offered by their employer. This brochure is designed as part of the information provided to each prospective member before enrollment. *Specific details of the Aetna plan offered by your employer are also provided in pre-enrollment information.* This document is available to any member of the general public upon request and on our public website at [www.aetna.com](http://www.aetna.com).

## Required Disclosure Information

Washington law requires us to provide the following information to you, upon request: (a) A listing of covered benefits, including prescription drug benefits, if any, a copy of the current formulary, if any is used, definitions of terms such as generic versus brand name, and policies regarding coverage of drugs, such as how they become approved or taken off the formulary, and how consumers may be involved in decisions about benefits; (b) A listing of exclusions, reductions, and limitations to covered benefits, and any definition of medical necessity or other coverage criteria upon which they may be based; (c) A statement of the carrier's policies for protecting the confidentiality of health information; (d) A statement of the cost of premiums and any enrollee cost-sharing requirements; (e) A summary explanation of the carrier's grievance process; (f) A statement about the availability of a point-of-service option, if any, and how the option operates; and (g) A convenient means of obtaining lists of participating primary care and specialty care providers, including disclosure of network arrangements that restrict access to providers within any plan network.

## Other Disclosure Information

Additionally, upon request, we will provide written information about any health benefits plan we offer including the following written information: (a) Any documents, instruments, or other information referred to in the medical coverage agreement; (b) A full description of the procedures to be followed by an enrollee for consulting a provider other than the primary care provider and whether the enrollee's primary care provider, the carrier's medical director, or another entity must authorize the referral; (c) Procedures, if any, that an enrollee must first follow for obtaining prior authorization for health care services; (d) A written description of any reimbursement or payment arrangements, including, but not limited to, capitation provisions, fee-for-service provisions, and health care delivery efficiency provisions, between a carrier and a provider or network; (e) Descriptions and justifications for provider compensation programs, including any incentives or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to specialists; (f) An annual accounting of all payments made by the carrier which have been counted against any payment limitations, visit limitations, or other overall limitations on a person's coverage under a plan; (g) A copy of the carrier's grievance process for claim or service denial and for dissatisfaction with care; and (h) Accreditation status with one or more national managed care accreditation organizations, and whether the carrier tracks its health care effectiveness performance using the health employer data information set (HEDIS), whether it publicly reports its HEDIS data, and how interested persons can access its HEDIS data. For more information, if you are a member, contact Member Services at the toll free number on your ID card. All others, contact your benefits administrator.

## Plan Benefits

Your plan of benefits is determined by your plan sponsor. The plan your employer chooses is underwritten or administered by Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, CT 06156, 1-888-982-3862. Covered services include most types of treatment provided by primary care physicians, specialists and hospitals. However, a health plan excludes and/or includes limits on coverage for some services, including but not limited to, cosmetic surgery and experimental procedures. In addition, in order to be covered, all services, including the location (type of facility), duration and costs of services, must be medically necessary as defined below and as determined by Aetna. The information that follows provides general information regarding Aetna health plans. For a complete description of the benefits available to you, including procedures to follow, exclusions and limitations, refer to your specific plan documents, which may include the Booklet-certificate, Group Agreement, Group Insurance Certificate, Group Policy and any applicable riders and amendments to your plan.

## How the Plan Works

### Member Cost Sharing

Cost sharing refers to the portion of medical services that you pay out of your own pocket. Refer to your plan documents to see which of the following cost-sharing provisions apply to your plan:

- Copay – This may be a flat fee that you pay directly to the health care provider at the time of service.
- Coinsurance – This is a percentage of the fees that you must pay toward the cost of some covered medical expenses. Your health care provider will bill you for this amount.
- Calendar Year Deductible – The amount of covered medical expenses you pay each calendar year before benefits are paid. There is a calendar-year deductible that applies to each person.
- Inpatient Hospital Deductible – The amount of covered inpatient hospital expenses you pay for each hospital confinement before benefits are paid. This deductible is *in addition to* any other copayments or deductibles under your plan.
- Emergency Room Deductible – The amount of covered hospital emergency room expenses you pay each year before benefits are paid. A separate hospital emergency room deductible applies to each visit by a person to a hospital emergency room unless the person is admitted to the hospital as an inpatient within 24 hours after a visit to a hospital emergency room.

The applicability and amount of each copay and deductible listed above will be determined by your plan sponsor and described in your plan documents.

### Your Primary Care Provider

Check your plan documents to see if your plan requires you to select a primary care provider (PCP). If a PCP is required, you must choose a provider from the Aetna network. You can look up network providers in a printed Aetna Provider Directory, or visit our DocFind® directory at [www.aetna.com](http://www.aetna.com). If you do not have Internet access and would like a printed directory, please contact Member Services at the toll-free number on your ID card and request a copy.

If your plan requires or encourages utilizing a PCP, you may choose a different PCP for each member of your family. When you enroll, indicate the name of the PCP you have chosen on your enrollment form. Or, call Member Services after you enroll to tell us your selection. The name of your PCP will appear on your Aetna ID card. You may change your selected PCP at any time. If you change your PCP, you will receive a new ID card.

Your PCP can provide primary health care services as well as coordinate your overall care. You should consult your PCP when you are sick or injured to help determine the care that is needed. If your plan requires referrals, your PCP should issue a referral to a participating specialist or facility for certain services. (See Referral Policy for details.)

### Referral Policy

Check your plan documents to see if your plan requires PCP referrals for specialty care. If referrals are required, you must see your PCP first before visiting a specialist or other outpatient provider for nonemergency or nonurgent care. Your PCP will issue a referral for the services needed.

If you do not get a referral when a referral is required, you may have to pay the bill yourself, or the service will be treated as nonpreferred if your plan includes out-of-network benefits. Some services may also require prior approval by us. See the Precertification section and your plan documents for details.

The following points are important to remember regarding referrals.

- The referral is how your PCP arranges for you to be covered at the in-network benefit level for necessary, appropriate specialty care and follow-up treatment.
- You should discuss the referral with your PCP to understand what specialist services are being recommended and why.

- If the specialist recommends any additional treatments or tests beyond those referred by the PCP, you may need to get another referral from your PCP before receiving the services.
- Except for emergency services, inpatient services require prior authorization by Aetna.
- Referrals are valid for 30 days.
- In plans with no out-of-network benefits, coverage for services from nonparticipating providers requires prior authorization by Aetna in addition to a special nonparticipating referral from the PCP, if your plan requires a PCP. When properly authorized, these services are fully covered, less the applicable cost sharing.
- The referral (and a precertification, if required) provides that, except for applicable cost sharing (that is, copays, coinsurance and/or deductibles), you will not have to pay the charges for covered expenses, as long as the individual seeking care is a member at the time the services are provided.

### Specialty Referral under Managed Care plans

Except for direct access benefits as explained below, specialist benefits may only be accessed with a referral from your PCP.

*Direct Access to Women’s Health Care Specialists.* Under Washington law, female members may self-refer to “Women’s Health Care Specialists” including physicians who specialize in women’s health care, Advanced Registered Nurse Practitioners (ARNPs) nurse midwives, licensed midwives, ARNPs and Physician Assistants (PAs) who specialize in women’s health care for women’s health care services including maternity.

*Direct Access to Chiropractors.* Under Washington law, members may self-refer to participating chiropractors for medically necessary care. This self-referral benefit may be subject to visit maximums. Refer to your Schedule of Benefits for information about your plan limits.

**Refer to your plan documents for other benefits that may not require a referral.**

### Precertification

Some health care services, like hospitalization and certain outpatient surgery, require “precertification.” This means the service must be approved by Aetna before it will be covered under the plan. Check your plan documents for a complete list of services that require this approval. When reviewing a precertification request, we will verify your eligibility and make sure the service is a covered expense under your plan. We also check the cost-effectiveness of the service and we may communicate with your provider if necessary. If you qualify, we may enroll you in one of our case management programs and have a nurse call to make sure you understand your upcoming procedure. When you visit a doctor, hospital or other provider that participates in the Aetna network, someone at the provider’s office will contact Aetna on your behalf to get the approval.

If your plan allows you to go outside the Aetna network of providers, you will have to get that approval yourself. In this case, it is your responsibility to make sure the service is precertified, so be sure to talk to your provider about it. If you do not get proper authorization for out-of-network services, you may have to pay for the service yourself. You cannot request precertification after the service is performed. To precertify services, call the number shown on your Aetna ID card. In plans that do not have out-of-network benefits, coverage for services from nonparticipating providers requires prior authorization by Aetna in addition to a special nonparticipating referral from the PCP. When properly authorized, these services are fully covered, less the applicable cost sharing.

### Health Care Providers

Check your plan documents and enrollment materials to see if your plan requires you to visit only network providers, or if you may visit any health care provider in or out of the Aetna network. When a plan includes out-of-network benefits, you generally pay more out of pocket when you visit a nonparticipating provider than when you visit a health care provider that participates in the Aetna network. Aetna participating providers may also handle certain tasks on your behalf; for example, obtaining precertification and filing claims.

Product	PCP Required?	Referrals Required?	Precertification Required
Open Choice	No	No	Yes
Managed Choice	Yes	Yes	Yes
Aetna Open Access Managed Choice	Encouraged	No	Yes
Elect Choice	Yes	Yes	Yes
Aetna Open Access Elect Choice	Encouraged	N/A	Yes

## Aetna Network Providers

In addition to the provider directory listing of participating providers, members can also conduct an online search for participating physicians, hospitals, dentists, pharmacies and other providers in their area through our DocFind® directory (updated three times a week) at [www.aetna.com](http://www.aetna.com). Members can select a PCP based on geographic location, group practice, medical specialty and/or hospital affiliation. DocFind also allows members to obtain other useful information not found in the directory, such as the providers' credentials and in some cases a Provider Performance Summary.

You can feel confident choosing a health care provider for you and your family from the Aetna network. That is because participating providers must first meet our standards. Before joining our network, these health care providers must pass a credentialing process that substantiates that they have appropriate credentials, including licenses, hospital privileges, education and work history. Our participating providers, including all PCPs, are independent contractors and are not agents or employees of Aetna Life Insurance Company.

## Transplants and Other Complex Conditions

Our National Medical Excellence Program® and other specialty programs help you access covered treatment for transplants and certain other complex medical conditions at participating facilities experienced in performing these services. Depending on the terms of your plan of benefits, you may be limited to only those facilities participating in these programs when needing a transplant or other complex condition covered.

## Provider Reimbursement

Participating providers are reimbursed on a discounted fee for service basis. Where the member is responsible for a coinsurance payment based on a percentage of the bill, the member's obligation is to be determined on the basis of the charges established by contract, if any, rather than on the basis of the provider's billed charges. If your plan provides coverage for services rendered by nonparticipating providers, we will determine the appropriate payment by referring to the customary amount paid to most providers for a given service in that geographic area. Our determination may be based on data from outside sources as well as our own data. We may also use computer software (including ClaimCheck®) and other tools to take into account factors such as the complexity, amount of time and degree of skill needed, and manner of billing. You may be responsible for any charges that we determine are not reasonable charges.

Aetna Pharmacy Management negotiates discounts from independent pharmacies, chain pharmacies, and mail vendors who accept our reimbursement rates for dispensing and ingredient costs in return for volume business. Our negotiated discounts are passed in full to our plan sponsors. The reimbursement formula is based on average wholesale price (AWP) less a negotiated discount, plus a dispensing fee. The dispensing fee is a contractual fee negotiated between Aetna Pharmacy Management and the network pharmacy. The negotiated rate self renews each year, unless it is changed contractually.

Where the member is responsible for a coinsurance payment based on a percentage of the bill, the member's obligation is to be determined on the basis of the charges established by contract, if any, rather than on the basis of the provider's billed charges.

## Provider Credentialing

All prospective participating providers must meet our high standards before being accepted into our network. For example, prospective PCPs must comply with more than two dozen criteria before they are certified and accepted. These criteria include:

- License and malpractice insurance
- Hospital privileges
- Provision of continuous, comprehensive care
- Emergency coverage
- Office appearance, cleanliness and equipment
- Organization of medical records
- Participation in continuing medical education programs

These providers are evaluated regularly for continued compliance with our criteria. This process includes a review of provider performance, office environment, patient charts, member surveys and member complaints. Results are submitted to a peer committee composed of physicians before participation is continued. Hospitals and ancillary providers are also reviewed for quality and appropriateness of care.

## How Aetna Pays Out-of-Network Providers

Some of our plans pay for services from providers who are not in our network. Many plans pay for services based on what is called the "reasonable," "usual and customary" or "prevailing" charge. Other plans pay based on our standard fees for care received from a network provider, or based on a percentage of Medicare's fees. ***When we pay less than what your provider charges, your provider may require you to pay the difference. This is true even if you have reached your plan's out-of-pocket***

**maximum.** Here is how we figure out what we will pay for each type of plan.

### **Prevailing Charge Plans**

*Step 1: We review the data.*

We get information from Ingenix, which is owned by United HealthCare. Health plans send Ingenix copies of claims for services they received from providers. The claims include the date and place of the service, the procedure code, and the provider's charge. Ingenix combines this information into databases that show how much providers charge for just about any service in any zip code.

*Step 2: We calculate the portion we pay.*

For most of our health plans, we use the 80th percentile to calculate how much to pay for out-of-network services. Payment at the 80th percentile means 80 percent of charges in the database are the same or less for that service in a particular zip code.

If there are not enough charges (less than 9) in the databases for a service in a particular zip code, we may use "derived charge data" instead. "Derived charge data" is based on the charges for comparable procedures, multiplied by a factor that takes into account the relative complexity of the procedure that was performed. We also use derived charge data for our student health plans and Aetna Affordable Health Choices® plans.

We also may consider other factors to determine what to pay if a service is unusual or not performed often in your area. These factors can include:

- The complexity of the service
- The degree of skill needed
- The provider's specialty
- The prevailing charge in other areas
- Aetna's own data

*Step 3: We refer to your health plan.*

We pay our portion of the prevailing charge as listed in your health plan. You pay your portion (called "coinsurance") and any deductible.

For example, your out-of-network provider charges \$120 for an office visit. Your plan covers 70 percent of the "reasonable," "usual and customary" or "prevailing" charge. Let's say the prevailing charge is \$100. And let's say you already met your deductible. Aetna would pay \$70. You would pay the other \$30. Your provider may also bill you for the \$20 difference between the prevailing charge (\$100) and the billed charge (\$120). In this case, your provider could bill you for a total of \$50.

### *The Prevailing Charge Databases*

The New York State Attorney General (NYAG) investigated the conflicts of interest related to the ownership and use of Ingenix data. Under an agreement with the NYAG, UnitedHealth Group agreed to stop using the Ingenix databases when an independent database (not owned by a health insurer) is created. In a separate agreement with NYAG in January 2009, Aetna agreed to use this new database when it is ready. We also will work with the new database owner to create online tools to give you better information about the cost of your care when using providers outside our network.

### **Fee Schedule Plans**

*Step 1: We compare the provider's bill to our fee schedule and your health plan.*

Your plan may say that we will pay the provider based on our fee schedule for network providers, or a certain percentage of that fee schedule, or a certain percentage of what Medicare pays. For example, your plan may say we pay 125 percent of what we pay a network provider for the same service.

Let's say you have your appendix removed. Our network rate for that surgery is \$1,600. We multiply \$1,600 by 125 percent to get \$2,000. We call this the "recognized" or "allowed" amount.

*Step 2: We calculate the portion we pay.*

Your plan also says that you must pay "coinsurance." This is your share of the "recognized" or "allowed" amount.

For example, your share may be 30 percent. In that case, we pay 70 percent of the \$2,000 allowed amount, which is \$1,400. You pay your provider your 30 percent coinsurance, which is \$600. Your provider may also ask you to pay the \$500 difference between the \$2,500 bill and the \$2,000 "recognized" or "allowed" amount. In this case, your provider could bill you \$1,100 in total.

### **Exceptions**

Some "prevailing charge" plans set the prevailing charge at a different percentile. For some claims (like those from hospitals and outpatient centers) we may use other information and data sources to determine the charge. And some of our plans pay based on a different kind of fee schedule. Also, for some non-participating providers we may pay based on other contractual arrangements.

Our provider claims codes and payment policies may also affect what we pay for a claim. Aetna may use computer software (including ClaimCheck®) and other tools to take into account factors such as the complexity, amount of time needed and manner of billing. The effects of these policies will be reflected in your Explanation of Benefits documents.

## Covered Benefits

Covered services include most types of treatment provided by physicians, other health care providers and hospitals. However, the benefits plan does exclude and/or include limits on coverage for some services, including but not limited to, cosmetic surgery and experimental procedures. In addition, in order to be covered, all services must be “medically necessary” as defined below and in the plan documents, and as determined by Aetna.

The information that follows provides general information about plans underwritten by Aetna Life Insurance Company. Members should consult their plan documents for a complete description of what health care services are covered and any applicable exclusions and limitations.

*Specific details of the Aetna plan offered by your employer are provided in pre-enrollment information.*

## Medically Necessary

“Medically necessary” means that the service or supply is provided by a physician or other health care provider exercising prudent clinical judgment for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that provision of the service or supply is:

- In accordance with generally accepted standards of medical practice; and
- Clinically appropriate in accordance with generally accepted standards of medical practice in terms of type, frequency, extent, site and duration, and considered effective for the illness, injury or disease; and
- Not primarily for the convenience of you, or for the physician or other health care provider; and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the illness, injury or disease.

For these purposes “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

## Emergency Care

If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world. An emergency medical condition is one manifesting itself by acute symptoms of sufficient severity such that a prudent person, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person’s health, or with respect to a pregnant woman, the health of the woman and her unborn child. Whether you are in or out of an Aetna service area, we simply ask that you follow the guidelines below when you believe you need emergency care.

- Call the local emergency hotline (ex. 911) or go to the nearest emergency facility. If a delay would not be detrimental to your health, call your doctor or PCP. Notify your doctor or PCP as soon as possible after receiving treatment.
- If you are admitted to an inpatient facility, you or a family member or friend on your behalf should notify your doctor, PCP or Aetna as soon as possible.

## What to Do Outside Your Aetna Service Area

If you are traveling outside your Aetna service area or if you are a student who is away at school, you are covered for emergency and urgently needed care. Urgent care may be obtained from a private practice physician, a walk-in clinic, an urgent care center or an emergency facility. Certain conditions, such as bleeding, severe vomiting or fever, are considered “urgent care” outside your Aetna service area and are covered in any of the above settings. If, after reviewing information submitted to us by the provider that supplied care, the nature of the urgent or emergency problem does not qualify for coverage, we may ask you for more information to qualify the coverage. We will send you an Emergency Room Notification Report to complete, or a Member Services representative can take this information by telephone.

## After-Hours Care

You may call your provider’s office 24 hours a day, 7 days a week if you have medical questions or concerns. You may also consider visiting participating Urgent Care facilities. See your plan documents for cost-sharing provisions for urgent care services.

## Exclusions

Aetna plans do not cover all health care expenses. Each plan has limitations and exclusions, which are detailed in the Booklet-Certificate. Consult your Booklet-Certificate for your plan's list of exclusions and limitations. In general, coverage is not provided for the following charges:

- Those for services and supplies not necessary, as determined by Aetna, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the attending health care provider or dentist.
- Those for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending health care provider or dentist.
- Those for or in connection with services or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:
  - there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or if required by the FDA, approval has not been granted for marketing; or
  - a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or
  - the written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease if Aetna determines that: the disease can be expected to cause death within one year, in the absence of effective treatment; and the care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

Also, this exclusion will not apply with respect to drugs that: have been granted treatment investigational new drug (IND) or Group C/treatment IND status; or are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; if Aetna determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

- Those for or related to services, treatment, education testing, or training related to learning disabilities or developmental delays.
- Those for care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury.
- Those for or related to the following types of treatment: primal therapy; rolfing; psychodrama; megavitamin therapy; bioenergetic therapy; vision perception training; or carbon dioxide therapy.
- Those for treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field.
- Those for services of a resident physician or intern rendered in that capacity.
- Those that are made only because there is health coverage.
- Those that a covered person is not legally obliged to pay.
- To the extent allowed by the law of the jurisdiction where the group contract is delivered, for those services and supplies:
  - Furnished by, paid for, or required for injuries or illnesses found by the Secretary of Veterans Affairs to have been incurred in or aggravated during the performance of uniformed service.
  - Furnished, paid for, or for which benefits are provided or required under any law of a government. (This exclusion will not apply to "no fault" auto insurance if it: is required by law; is provided on other than a group basis; and is included in the definition of Other Plan in the section entitled Effect of Benefits Under Other Plans Not Including Medicare of the Booklet-Certificate. In addition, this exclusion will not apply to: a plan established by government for its own employees or their dependents; or Medicaid.)
- Those for or related to any eye surgery mainly to correct refractive errors.
- Those for education, special education, or job training whether or not given in a facility that also provides medical or psychiatric treatment.

- Those for plastic surgery, reconstructive surgery (except in connection with a mastectomy), cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to: Improve the function of a part of the body that is not a tooth or structure that supports the teeth; and is malformed as a result of a congenital abnormality; including harelip, webbed fingers, or toes; or as a direct result of disease; or surgery performed to treat a disease or injury.
- Those for therapy, supplies, or counseling for sexual dysfunctions or inadequacies.
- Those for or related to sex change surgery or to any treatment of gender identity disorders.
- Those for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures.
- Those for or in connection with marriage, family, child, career, social adjustment, pastoral, or financial counseling.
- Those for or in connection with speech therapy. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words, and form sentences) as the result of a disease or injury.
- Those to the extent they are not reasonable charges, as determined by Aetna.
- Those for a voluntary sterilization procedure or, the reversal of a sterilization procedure.

## Prescription Drugs

If your plan covers outpatient prescription drugs, your plan may include a preferred drug list (also known as a “drug formulary”). The preferred drug list includes prescription drugs that, depending on your prescription drug benefits plan, are covered on a preferred basis. Many drugs, including many of those listed on the preferred drug list, are subject to rebate arrangements between Aetna and the manufacturer of the drugs. Such rebates are not reflected in and do not reduce the amount you pay to your pharmacy for a prescription drug. In addition, in circumstances where your prescription plan utilizes copayments or coinsurance calculated on a percentage of the cost of a drug or a deductible, it is possible for your cost to be higher for a preferred drug than it would be for a nonpreferred drug. For information regarding how medications are reviewed and selected for the preferred drug list, please refer to [www.aetna.com](http://www.aetna.com) or the Aetna Preferred Drug (Formulary) Guide. Printed Preferred Drug Guide information will be provided upon request or, if applicable, annually for current members and upon

enrollment for new members. For more information, call Member Services at the toll-free number on your ID card.

The medications listed on the preferred drug list are subject to change in accordance with applicable state law. Your prescription drug benefit is generally not limited to drugs listed on the preferred drug list. Medications that are not listed on the preferred drug list (nonpreferred or nonformulary drugs) may be covered subject to the limits and exclusions set forth in your plan documents. Covered nonformulary prescription drugs may be subject to higher copayments or coinsurance under some benefit plans. Some prescription drug benefit plans may exclude from coverage certain nonformulary drugs that are not listed on the preferred drug list. If it is medically necessary for you to use such drugs, your physician, you or our authorized representative (or pharmacist in the case of antibiotics and analgesics) may contact Aetna to request coverage as a medical exception. Check your plan documents for details.

In addition, certain drugs may require precertification or step therapy before they will be covered under some prescription drug benefit plans. Step therapy is a different form of precertification that requires a trial of one or more “prerequisite-therapy” medications before a “step-therapy” medication will be covered. If it is medically necessary for you to use a medication subject to these requirements prior to completing the step therapy, your physician, you or your authorized representative can request coverage of such drug as a medical exception. In addition, some benefit plans include a mandatory generic drug cost-sharing requirement. In these plans, you may be required to pay the difference in cost between a covered brand-name drug and its generic equivalent in addition to your copayment if you obtain the brand-name drug. Nonprescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received and/or available upon enrollment) are not covered, and medical exceptions are not available for them.

Depending on the plan selected, new prescription drugs not yet reviewed for possible addition to the preferred drug list are either available at the highest copay under plans with an “open” formulary, or excluded from coverage unless a medical exception is obtained under plans that use a “closed” formulary. These new drugs may also be subject to precertification or step therapy. Ask your treating physician(s) about specific medications. Refer to your plan documents or contact Member Services for information regarding terms, conditions and limitations of coverage. If you use the Aetna Rx Home Delivery® mail-order prescription program or the Aetna Specialty Pharmacy® specialty drug program, you will be acquiring these prescriptions through an affiliate of Aetna. Aetna Rx Home Delivery’s and Aetna Specialty Pharmacy’s cost of purchasing drugs takes into account discounts, credits and other amounts they may receive from wholesalers,

manufacturers, suppliers and distributors. The negotiated charge with Aetna Rx Home Delivery, LLC. and Aetna Specialty Pharmacy may be higher than the cost of purchasing drugs and providing pharmacy services.

### Prescription Drug Definitions

- Brand-Name Prescription Drug(s) – A prescription drug which is protected by trademark registration.
- Medication Formulary – A listing of prescription drugs that have been evaluated and selected by Aetna clinical pharmacists for their therapeutic equivalency and efficacy. This listing includes both brand-name drugs and generic drugs and is subject to periodic review and modification by Aetna.
- Generic Prescription Drug(s) – A prescription drug that is not protected by trademark registration, but is produced and sold under the chemical formulation name.
- Prescription Drugs – Any of the following:
  - A drug, biological, or compounded prescription which, by federal law, may be dispensed only by prescription and that is required to be labeled “Caution: Federal law prohibits dispensing without prescription”
  - Injectable insulin
  - Disposable needles and syringes which are purchased to administer insulin
  - Disposable diabetic supplies
- Precertification Program – For certain outpatient prescription drugs, prescribing health care providers must contact Aetna or an affiliate to request and obtain coverage for such drugs. The list of drugs requiring precertification is subject to change by Aetna or an affiliate. An updated copy of the list of drugs requiring precertification is available to members upon request.
- Step Therapy Program – A form of precertification under which certain prescription drugs will be excluded from coverage, unless a first-line therapy drug(s) is used first. The list of step-therapy drugs is subject to change by Aetna or an affiliate. An updated copy of the list of drugs subject to step therapy is available to members upon request.

### Exclusions and Limitations

*Does this plan limit or exclude certain drugs my health care provider may prescribe, or encourage substitutions for some drugs?*

All prescription drug plans contain limitations and exclusions on the type of drugs that are covered. Depending on the plan design, the following are examples of some of the types of limitations which may apply. In general, coverage is not provided for the following charges:

- For a device of any type unless specifically included as a prescription drug. For example, prescription contraceptive devices are covered as prescription drugs
- For any drug entirely consumed at the time and place it is prescribed
- For less than a 30-day supply or 90-unit doses of any drug dispensed by a mail-order pharmacy
- For more than a 30-day supply or 90-unit doses per prescription or refill. However, this limitation does not apply to a supply of up to 90 days per prescription or refill for drugs that are provided by a mail-order pharmacy
- For the administration or injection of any drug
- For any refill of a drug if it is more than the number of refills specified by the prescriber. Before recognizing charges, we may require a new prescription or evidence as to need:
  - If the prescriber has not specified the number of refills
  - If the frequency or number of prescriptions or refills appears excessive under accepted medical practice standards
- For any refill of a drug dispensed more than one year after the latest prescription for it or as permitted by the law of the jurisdiction in which the drug is dispensed
- For any drug provided by or while the person is an inpatient in any health care facility; or for any drug provided on an outpatient basis in any health care facility to the extent benefits are paid for it under any other part of this plan or under any other medical or prescription drug expense benefit plan carried or sponsored by your employer
- For immunization agents
- For biological sera and blood products
- For vitamins
- For nutritional supplements
- For any fertility drugs
- For a prescription drug dispensed by a mail-order pharmacy that is not a preferred pharmacy

**Precertification Program:** Your pharmacy benefits plan may include our precertification program. Precertification helps encourage the appropriate and cost-effective use of certain drugs. It is your responsibility to arrange for your health care provider to call the number shown on your ID card to request certification. This call must be made as soon as reasonably possible before the drug is to be dispensed. Copies of laboratory and/or medical records may be requested. If such information is requested, it must be provided in order to certify the necessity of the drug. Refer to the Precertification List in the Aetna Medication Formulary Guide to determine which prescription drugs require precertification. The precertification list is subject to periodic review and modification by Aetna. The precertification program is based on current medical findings, manufacturer labeling, FDA guidelines and cost information. For these purposes, cost information includes any rebate arrangements between Aetna and manufacturers for the benefit of Aetna. The drugs requiring precertification are subject to change. Visit our website at [www.aetna.com](http://www.aetna.com) for the current precertification list. Please refer to your Prescription Drug Rider to see if precertification applies to your plan.

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

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

### **Changes to the Approved Drug List**

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

Since we are regularly evaluating both new and existing therapies, our formulary is subject to change. Aetna encourages the use of generic drugs when appropriate. The Food and Drug Administration (FDA) has deemed that generic drugs are therapeutically equivalent to brand-name drugs. Generic drugs must contain the same active ingredients in the same amounts as their brand-name counterparts. Additionally, the same FDA quality and safety

standards apply to generic drugs and brand-name drugs. Furthermore, generic drugs may help lower your health care expenses. Under some Aetna prescription drug benefit plans, members pay a lower copayment if they choose generic drugs over brand-name medications. Until a new brand name FDA-approved drug has been reviewed by the Aetna P&T Committee and a formulary determination is made by Aetna, it will not be listed on the formulary. Under closed formulary plans such drugs will require your health care provider to obtain a medical exception. For open formulary plans, the new drug will be covered at the highest copay.

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

### **Requesting Coverage for Excluded Drugs**

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

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

Clinical Policy Bulletins, which detail general criteria used in determining medical exceptions for many drugs, are available on our website [www.aetna.com](http://www.aetna.com). You may also contact Member Services at the number on your ID Card to request the Clinical Policy Bulletin for a specific drug, if one is available.

If Aetna denies your provider's precertification request or medical exception request, you or your provider acting on your behalf may file an appeal (oral or written) according to the Appeal Procedures outlined in your plan documents, and briefly described in this disclosure. You may contact Member Services at the toll-free number shown on your ID card to file an appeal. See the Appeal Procedures in this disclosure or your Booklet-Certificate for more information regarding the appeal process.

### **Out-of-Pocket Costs for Prescription Drugs**

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

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

### **Where to Buy Prescription Drugs**

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

*Participating Retail Pharmacies:* With any Aetna prescription drug plan, you can fill your prescriptions easily at our participating pharmacies. There are over 59,000 participating pharmacies nationally, including the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. Participating pharmacies in the state of Washington are listed in the pharmacy directory, or may be found on DocFind at [www.aetna.com](http://www.aetna.com).

The maximum supply available from a participating retail pharmacy per copay is a 30-day supply. The maximum supply available per copayment from a participating mail-order pharmacy is a 90-day supply. Your prescription will indicate the number of refills your provider has authorized. Any refill in excess of the amount indicated on the prescription will not be covered. If you need a supply greater than the maximum due to travel, your provider may contact us to request an exception to the supply limitations. Additional copayments may apply to approved exceptions. Supply exception requests will be considered on an individual case basis.

Before filling prescriptions, we may require a new prescription or evidence as to need if a prescription or refill appears excessive under accepted medical practice standards. Prescription orders filled prior to the effective date or after the termination date of your eligibility will not be covered. Replacement for lost or stolen prescriptions will not be covered. Always present your Aetna ID card at a participating pharmacy. This will help ensure that you will only be required to pay the appropriate amount under your benefits plan. Please keep in mind that if you get your prescription filled at a participating pharmacy and don't present your ID card, but rather pay for the prescription and submit a claim for reimbursement, you may not be reimbursed the full amount you paid. For instance, we will deduct from your reimbursement your copay amount, and depending on your plan design, we may reimburse you at the pharmacy's contracted rate, which may be less than the amount you paid out-of-pocket, or we may deny your claim altogether.

*Non-Participating Retail Pharmacies:* You may also fill your prescriptions at nonparticipating pharmacies. Bring your prescription and your Aetna ID card to a nonparticipating pharmacy and pay the full cost of the drug. You may then submit a claim form for reimbursement. However, under most benefit plans because you did not use a participating pharmacy, you will not be reimbursed the full cost of the drug. To receive the reimbursement you need to submit a claim form and the prescription receipt.

In an emergency or urgent care situation, you can fill your prescription at a nonparticipating pharmacy. The prescription drug charge for an emergency condition may be reimbursed at the preferred level of coverage. In this case, you will need to pay the pharmacy directly and submit a claim to Aetna for reimbursement under the terms of your plan. You may contact Member Services to order prescription drug claim forms or to submit emergency claims from a nonparticipating pharmacy.

*Mail-Order Prescriptions:* Your prescription drug benefit may include mail-order delivery. You can order up to a 90-day supply of covered medications (if authorized by your physician) from a participating mail-order pharmacy. Medications most appropriate for mail order are those you take continuously, such as for the treatment of a chronic condition like arthritis, diabetes or heart disease. When it is time for a refill, you may call the mail-order pharmacy and place your request. For more information, please refer to your benefit plan documents or call the Member Services number on your ID card.

*Other Prescription Drug Services: (What other prescription drug services does my health plan cover?)* Our prospective, concurrent, and retrospective drug utilization review (DUR) programs help promote safe and appropriate dispensing.

We provide:

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

In addition, by going to our [www.aetna.com](http://www.aetna.com) website, the following information and services specific to pharmacy are available:

- Pharmacy Directories: Search the DocFind directory for participating pharmacies.
- Formulary, Precertification and Step-Therapy Information: Current formulary precertification and step-therapy information is available to customers, members and providers. Users can inquire about a specific drug using the formulary search engine this site provides.
- Claim Forms. Members can contact member services to order prescription drug claim forms to submit for reimbursement when utilizing a nonparticipating pharmacy.

#### **Your Right to Safe and Effective Pharmacy Services**

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan and what coverage limitations are in your contract. If you would like more information about the drug coverage policies under this plan, or if you have a question or concern about your pharmacy benefit, please contact Aetna at 1-800-323-9930 or call the number on your ID card. If you would like to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract, you may contact the Washington State Office of Insurance Commissioner at 1-800-562-6900. If you have a concern about the pharmacists or pharmacies serving you, please call the State Department of Health at 1-360-236-4825.

## **Behavioral Health Benefits**

### **Behavioral Health Network**

Behavioral health care services are managed by Aetna. As a result, Aetna is responsible for making initial coverage determinations and coordinating referrals to the Aetna provider network. As with other coverage determinations, you may appeal adverse behavioral health care coverage determinations in accordance with the terms of your health plan.

The type of behavioral health benefits available to you depends on the terms of your health plan and state law. If your health plan includes behavioral health services, you may be covered for mental health conditions and/or drug and alcohol abuse services, including inpatient and outpatient services, partial hospitalizations and other behavioral health services. You can determine the type of behavioral health coverage available under the terms of your plan and how to access services by calling the Aetna Member Services number listed on your ID card.

If you have an emergency, call 911 or your local emergency hotline, if available. For routine services, access covered behavioral health services available under your health plan by the following methods:

- Call the toll-free Behavioral Health number (where applicable) listed on your ID card or, if no number is listed, call the Member Services number listed on your ID card for the appropriate information.
- Where required by your plan, call your PCP for a referral to the designated behavioral health provider group.
- When applicable, an employee assistance or student assistance professional may refer you to your designated behavioral health provider group.

You can access most outpatient therapy services without a referral or preauthorization. However, you should first consult Member Services to confirm that any such outpatient therapy services do not require a referral or preauthorization.

### **Behavioral Health Provider Safety Data Available**

For information about our Behavioral Health provider network safety data, visit [www.aetna.com/docfind](http://www.aetna.com/docfind) and select the "Get info on Patient Safety and Quality" link. If you do not have Internet access, you may call Member Services at the toll-free number shown on your Aetna ID card to request a printed copy of this information.

## Behavioral Health Depression Prevention Programs

Aetna Behavioral Health offers two prevention programs for our members: Perinatal Depression Education, Screening and Treatment Referral Program, also known as Beginning Right® Depression Program, and Identification and Referral of Adolescent Members Diagnosed With Depression Who Also Have Comorbid Substance Abuse Needs. For more information on either of these prevention programs and how to use the programs, ask Member Services for the phone number of your local Care Management Center.

## Other Services and Information About Your Plan

### Advance Directives

There are three types of advance directives:

- Durable power of attorney – appoints someone you trust 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 to be given CPR if your heart stops or be intubated if you stop breathing.

You can create an advance directive in several ways:

- Get an advance medical directive form from a health care professional. Certain laws require health care facilities that receive Medicare and Medicaid funds to ask all patients at the time they are admitted if they have an advance directive. You don't need an advance directive to receive care. But we are required by law to give you the chance to create one.
- Ask for an advance directive form at a state or local office on aging, bar associations, legal service programs, or your local health department.
- Work with a lawyer to write an advance directive.
- Create an advance directive using computer software designed for this purpose.
- If you are not satisfied with the way Aetna handles advance directives, you can file a complaint with your Medicare State Certification Agency. Visit [www.medicare.gov](http://www.medicare.gov) for information on specific state agencies or call 1-800-MEDICARE (1-800-633-4227) (TTY/TDD: 1-877-486-2048).

Source: American Academy of Family Physicians. *Advanced Directives and Do Not Resuscitate Orders*. January 2009. Available at <http://familydoctor.org/003.xml?printxml>. Accessed February 20, 2009.

## Technology Review

We review new medical technologies, behavioral health procedures, pharmaceuticals and devices to determine which ones should be covered by our plans. And we even look at new uses for existing technologies. To review these innovations, we may:

- Study published medical research and scientific evidence on the safety and effectiveness of medical technologies.
- Consider position statements and clinical practice guidelines from medical and government groups, including the federal Agency for Health Care Research and Quality.
- Seek input from relevant specialists and experts in the technology.
- Determine whether the technologies are experimental or investigational.

You can find out more on new tests and treatments in our Clinical Policy Bulletins. See Clinical Policy Bulletins below for more information.

### Clinical Policy Bulletins

Clinical Policy Bulletins (CPBs) describe our policy determinations of whether certain services or supplies are medically necessary or experimental or investigational, based on a review of currently available clinical information. Clinical determinations in connection with individual coverage decisions are made on a case-by-case basis consistent with applicable policies.

Aetna CPBs do not constitute medical advice. Treating providers are solely responsible for medical advice and for your treatment. You should discuss any CPB related to your coverage or condition with your treating provider.

While Aetna CPBs are developed to assist in administering plan benefits, they do not constitute a description of plan benefits. Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. You and your providers will need to consult the benefit plan to determine if there are any exclusions or other benefit limitations applicable to this service or supply.

CPBs are regularly updated and are therefore subject to change. Aetna CPBs are available at [www.aetna.com](http://www.aetna.com) under "Members" and then "Health Coverage Information." If you do not have Internet access, please contact Member Services at the toll-free number on your ID card for information about specific Clinical Policy Bulletins.

## Utilization Review/Patient Management

We have developed a patient management program to assist in determining what health care services are covered under the health plan and the extent of such coverage.

The program assists you in receiving appropriate health care and maximizing coverage for those health care services. 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. In certain cases, we review your request to be sure the service or supply is consistent with established guidelines and is a covered benefit under your plan. We call this “utilization management review.”

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 the precertification, concurrent review and retrospective review processes. To the extent that certain Utilization Review/Patient Management functions are delegated to IDSS, IPAs or other provider groups (“Delegates”), such Delegates utilize criteria that they deem appropriate. Utilization Review/Patient Management policies may be modified to comply with applicable state law.

Only medical professionals make decisions denying coverage for services for reasons of medical necessity. Coverage denial letters for such decisions delineate any unmet criteria, standards and guidelines, and inform the provider and you of the appeal process. For more information concerning utilization management, you may request a free copy of the criteria we use to make specific coverage decisions by contacting Member Services. You may also visit [www.aetna.com/about/cov\\_det\\_policies.html](http://www.aetna.com/about/cov_det_policies.html) to find our Clinical Policy Bulletins and some utilization review policies. Doctors or health care professionals who have questions about your coverage can write or call our Patient Management department. The address and phone number are on your ID card.

## Concurrent Review

Concurrent review is a review conducted while a patient is confined on an inpatient basis. The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members receiving inpatient services. All inpatient services extending beyond the initial certification period require concurrent review.

## Discharge Planning

Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits that may to be utilized by you upon discharge from an inpatient stay.

## Retrospective Record Review

Retrospective review is a review conducted after the patient has been discharged from the hospital or facility. The purpose of retrospective review is to analyze potential quality and utilization issues, initiate appropriate follow-up action based on quality or utilization issues, and review all appeals of inpatient concurrent review decisions for coverage of health care services. Our effort to manage the services provided to you includes the retrospective review of claims submitted for payment, and of medical records submitted for potential quality and utilization concerns.

URAC Accreditation - The American Healthcare Commission/Utilization Review Accreditation Commission (URAC), the leading accreditation organization for traditional health insurers, has awarded our utilization management program for PPO and indemnity products offered through Aetna Life Insurance Company, two year full accreditation-its highest level of endorsement.

## Complaints, Appeals and External Review

This Complaint Appeal and External Review process may not apply if your plan is self-funded. Contact your Benefits Administrator if you have any questions.

## About Coverage Decisions

Sometimes we receive claims for services that may not be covered by your health benefits plan. It can be confusing — even to your providers. Our job is to make coverage decisions based on your specific benefits plan.

If a claim is denied, we'll send you a letter to let you know. If you don't agree you can file an appeal. To file an appeal, follow the directions in the letter that explains that your claim was denied. Our appeals decisions will be based on your plan provisions and any state and federal laws or regulations that apply to your plan. You can learn more about the appeal procedures for your plan from your plan

## Filing a Complaint or Appeal

We are committed to addressing your coverage issues, complaints and problems. If you have a coverage issue or other problem, call Member Services at the toll-free number on your ID card or e-mail us from your secure Aetna Navigator® member website. Click on “Contact Us” after you log on. You can also contact Member Services at: [www.aetna.com](http://www.aetna.com). If Member Services is unable to resolve your issue to your satisfaction, it will be forwarded to the appropriate department for handling.

If you are dissatisfied with the outcome of your initial contact, you may file an appeal. Your appeal will be decided in accordance with the procedures applicable to your plan and applicable state law. Refer to your plan documents for details regarding your plan’s appeal procedure.

- An appeal is defined as a written or oral request for review of a decision that has denied in whole or in part, after consideration of any relevant information, a request for claim payment, certification, eligibility, referral, etc.
- An “adverse determination” is defined as a decision by Aetna to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits including the admission to or continued stay in a facility.

### Appeal Review

- An appeal must be submitted to us within 180 days of the date we provided notice of denial. The Aetna address is on your ID card.
- An acknowledgment letter will be sent to you within 5 days of our receipt of the appeal. This letter may request additional information. If so, the additional information must be submitted to us within 15 days of the date of the letter.
- You will be sent a response within 30 days of our receipt of the appeal. The response will be based on the information provided with or subsequent to the appeal.
- Our final response will be sent within 30 days from the date of our first response letter.
- If additional time is needed to resolve the appeal, we will provide a written notice indicating additional time is needed, explaining why such time is needed, and setting a new date for a response. The additional time will not be extended beyond another 30 days.

- In any urgent or emergency situation, you or your health care provider may call Member Services to initiate an Expedited Appeal. The Member Services telephone number is on your ID card. A verbal response to the appeal will be given to the provider within 2 business days after we receive all necessary information. Written notice of the decision will be sent within 2 business days of our verbal response. If you are dissatisfied with our response, you may request and External Review.

### Standard Review of Adverse Determinations.

You, your authorized representative or your provider acting on your behalf may submit an appeal of an adverse determination orally or in writing.

We will issue a written decision to you within 14 days after we receive an appeal and all information necessary to complete our review of the appeal. If a decision cannot be made within 14 days due to circumstances beyond our control, we will notify you that an extension is necessary to complete the review. The extension will not delay a decision beyond 30 days of the receipt of the appeal without your informed, written consent.

In any urgent or emergency situation, your or your health care provider may call Member Services to initiate an Expedited Appeal procedure. Member Services telephone number is on your ID card. A verbal response to the appeal will be given to the provider within 72 hours after we receive all necessary information. Written notice of the decision will be sent within 2 business days of our verbal response. This written notice will include: the reasons for the determination, instructions for obtaining an appeal of the decision, clinical rationale for the decision, and instructions for obtaining the clinical review criteria used to make the determination. If you are dissatisfied with our response, the appeal procedure outlined above may be utilized.

Appeals of adverse determinations will be evaluated by an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed.

The clinical peer(s) deciding the appeal will not include any person involved in the initial adverse determination.

### External Review

If, after exhausting the internal appeals procedure you, your physician, or the hospital is still dissatisfied with our response, you may be eligible to request an External Review. A request for an External Review must be submitted within 180 calendar days from the date you receive your final determination letter. The final determination letter will instruct you on how to submit a request for an External Review.

Members have the right to appeal any (eligibility, services not covered) decision to an independent medical review. The right to independent medical review is not restricted to denials based on medical necessity or experimental and investigative.

For more information on the External Review Program you may call Member Services at the toll-free number shown on your ID card.

For self-insured plans, we established an external review process to give you the opportunity of requesting an objective and timely independent review of certain coverage denials. Once the applicable appeal process has been exhausted, you may request an external review of the decision if the coverage denial, for which you would be financially responsible, involves more than \$500, and is based on lack of medical necessity or on the experimental or investigational nature of the proposed service or supply.

For fully insured plans in Washington, if you are not satisfied with the outcome of your appeal, you have 180 days after the appeal process is concluded to request an independent review.

An Independent Review Organization (IRO) will assign the case to a physician reviewer with appropriate expertise in the area in question. After all necessary information is submitted, an external review generally will be decided within 30 calendar days of the request.

Expedited reviews are available when your health care provider certifies that a delay in service would jeopardize your health. Once the review is complete, the plan will abide by the decision of the external reviewer. The charges by the IRO will be borne by Aetna.

For further details regarding your plan's appeal process and the availability of an external review process, call the Member Services toll-free number listed on your ID card or visit our website [www.aetna.com](http://www.aetna.com) where you may obtain an external review request form. You also may call your state insurance or health department or consult their website for additional information regarding state mandated external review procedures.

## Member Rights & Responsibilities

You have the right to receive a copy of our Member Rights and Responsibilities Statement. This information is available to you at [www.aetna.com/about/MemberRights](http://www.aetna.com/about/MemberRights). You can also obtain a print copy by contacting Member Services at the number on your ID card.

## Member Services

To file a complaint or an appeal, for additional information regarding copayments and other charges, information regarding benefits, to obtain copies of plan documents, information regarding how to file a claim or for any other

question, you can contact Member Services at the toll-free number on your ID card, or email us from your secure Aetna Navigator member website at [www.aetna.com](http://www.aetna.com). Click on "Contact Us" after you log on.

*Spanish-speaking hotline – 1-800-533-6615*

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

## Interpreter/Hearing Impaired

When you require assistance from an Aetna representative, call us during regular business hours at the number on your ID card. Our representatives can:

- Answer benefits questions
- Help you get referrals
- Find care outside your area
- Advise you on how to file complaints and appeals
- Connect you to behavioral health services (if included in your plan)
- Find specific health information
- Provide information on our Quality Management program, which evaluates the ongoing quality of our services

*TDD Member Services – 1-800-628-3323 (hearing impaired only)*

## Quality Management Programs

We have a comprehensive quality measurement and improvement strategy, and do not view it as an isolated, departmental function. Rather, we integrate quality management and metrics into all that we do. For details on our program, goals and our progress on meeting those goals, go to [www.aetna.com/members/health\\_coverage/quality/quality.html](http://www.aetna.com/members/health_coverage/quality/quality.html). If you do not have Internet access and would like a hard copy of the information referenced here, please contact Member Services at the toll-free number on your ID card and request a copy.

## Privacy Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to your physical or mental health or condition, the provision of health care to you, or payment for the provision of health care to you. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify you.

When necessary or appropriate for your care or treatment, the operation of our health plans, or other related

activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. Participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claims payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health claims analysis and reporting; health services research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health plans. To the extent permitted by law, we use and disclose personal information as provided above without your consent. However, we recognize that you may not want to receive unsolicited marketing materials unrelated to your health benefits. We do not disclose personal information for these marketing purposes unless you consent. We also have policies addressing circumstances in which you are unable to give consent.

To request a printed copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please write to:

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

You can also visit [www.aetna.com](http://www.aetna.com) and link directly to the Notice of Privacy Practices by selecting the "Privacy Notices" link at the bottom of the page.

## **Non-discrimination statement**

Aetna does not discriminate in providing access to health care services on the basis of race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national origin. We are required to comply with Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, other laws applicable to recipients of federal funds, and all other applicable laws and rules.

## **Use of Race, Ethnicity and Language Data**

Aetna members have the option to provide us with race/ethnicity and preferred language information. This information is voluntary and confidential. We collect this information to identify, research, develop, implement and/or enhance initiatives to improve health care access, delivery and outcomes for diverse members, and otherwise improve services to our members. We will maintain administrative, technical and physical safeguards to protect information concerning member race, ethnicity and language preference from inappropriate access, use or disclosure. This data will be collected, used or disclosed only in accordance with Aetna policies and applicable state and federal requirements. It is not used to determine eligibility, rating or claim payment. For more information, please visit [www.aetna.com](http://www.aetna.com). If you do not have Internet access and would like a hard copy of the information referenced here, please contact Member Services at the toll-free number on your ID card and request a copy.

## **Notice Regarding Women's Health and Cancer Rights Act**

Under this health plan, coverage will be provided to a person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy for:

- (1) 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 lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

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

# Health Insurance Portability and Accountability Act

The following information is provided to inform you of certain provisions contained in the Group Health Plan, and related procedures that may be utilized by you in accordance with Federal law.

## Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing to your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing to the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after marriage, or 60 days after birth, adoption or placement for adoption if your premium is impacted by the birth, adoption or placement for adoption. To request special enrollment or obtain more information, contact your benefits administrator.

## Request for Certificate of Creditable Coverage

If you are a member of an insured plan sponsor or a member of a self-insured plan sponsor who have contracted with us to provide Certificates of Prior Health Coverage, you have the option to request a certificate.

This applies to you if you are a terminated member, or are a member who is currently active but would like a certificate to verify your status. As a terminated member, you can request a certificate for up to 24 months following the date of your termination. As an active member, you can request a certificate at any time. To request a Certificate of Prior Health Coverage, please contact Member Services at the telephone number listed on your ID card.

Health benefits and health insurance plans are underwritten or administered by Aetna Life Insurance Company. 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. Information subject to change.

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 accreditation status can be found on the NCQA website located at <http://www.ncqa.org/tabid/142/Default.aspx>.

To refine your search, we suggest you search these areas: **Managed Behavioral Healthcare Organizations** – for behavioral health accreditation; **Credentials Verification Organizations** – for credentialing certification; **Managed Care Organizations** – for HMO and PPO health plan accreditation; **Recognition Directory** – for physicians recognized by NCQA in the areas of heart/stroke care, diabetes care, back pain and systematic processes.

Health care providers who have been duly recognized by the NCQA Recognition Programs are annotated in the Physician 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. For up-to-date information, please visit our DocFind® directory at [www.aetna.com](http://www.aetna.com) or, if applicable, visit the NCQA's new top-level recognition listing at [www.ncqa.org/tabid/58/Default.aspx](http://www.ncqa.org/tabid/58/Default.aspx). If you do not have access to the Internet and would like a printed physician directory, please contact Member Services at the toll-free number shown on your Aetna ID card.

If you require language assistance from an Aetna representative, please call the Member Services number located on your ID card, and you will be connected with the language line if needed; or you may dial direct at 1-888-982-3862 (140 languages are available. You must ask for an interpreter).  
TDD 1-800-628-3323 (hearing impaired only).

Si requiere la asistencia de un representante de Aetna que hable su idioma, por favor llame al número de Servicios al Miembro que aparece en su tarjeta de identificación y se le comunicará con la línea de idiomas si es necesario; de lo contrario, puede llamar directamente al 1-888-982-3862 (140 idiomas disponibles. Debe pedir un intérprete). TDD-1-800-628-3323 (sólo para las personas con impedimentos auditivos).