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Important information you should know before you enroll in this health plan

AETNA HEALTH OF CALIFORNIA INC. (AETNA)

**HMO, Aetna HealthFund[®] HMO, QPOS[®], PrimeCare Physicians Plan, Aetna ValueNetworkSM,
Vitalidad Mexico con AetnaSM, Aetna Basic HMO**

2850 SHADELANDS DRIVE
WALNUT CREEK, CA 94598



IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at **1-877-287-0117**.

IMPORTANTE: ¿Puede leer esta carta? En caso de no poder leerla, le brindamos nuestra ayuda. También puede obtener esta carta escrita en su idioma. Para obtener ayuda gratuita, por favor llame de inmediato al **1-877-287-0117**.

www.aetna.com

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This consumer disclosure is a summary of the Aetna health plans listed above

Please read this disclosure form fully and carefully. It contains important information you should know before you enroll. If you have special health care needs, you should carefully read those sections that apply to you.

This disclosure may occasionally refer to your “plan documents.” They may include your Evidence of Coverage (EOC), Schedule of Benefits, Group Agreement, Group Insurance Certificate, Group Insurance Policy and/or any riders and updates that come with them. Your “plan documents” list all the details for the plan you chose, such as what’s covered, what’s not covered and what you will pay for services.

You can get a copy of your plan documents from your employer, or call us at **1-800-756-7039**.

The EOC includes information about:

- Your primary care physician (PCP)
- Participating providers
- Referrals and authorization
- Requesting continuity of care or standing referrals
- Facilities
- Grievance procedures
- How we determine medical necessity

If there is a conflict between the group contract and the EOC, the EOC will govern.

You can also find information online at **www.aetna.com**:

- Use our network search tool
- Access our prescription drug formulary
- Read coverage policy bulletins and more

You can also contact the California Department of Managed Health Care at **www.dmhc.ca.gov**.

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Get plan information online and by phone

If you're already enrolled in an Aetna health plan

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

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

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

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

Then you can log in any time to:

- Verify who's covered and what's covered
- Access your "plan documents"
- Track claims or view past copies of Explanation of Benefits statements
- Use the DocFind® search tool to find network care
- Use our cost-of-care tools so you can *know before you go*
- Learn more about and access any wellness programs that come with your plan

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

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

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

- Find a doctor or facility
- View alerts and messages
- View your claims, coverage and benefits
- View your ID card information
- Use the Member Payment Estimator
- Contact us by phone or e-mail

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

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

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

You can also speak with a representative to:

- Understand how your plan works or what you will pay
- Get information about how to file a claim
- Get a referral
- Find care outside your area
- File a complaint or appeal
- Get copies of your plan documents
- Connect to behavioral health services (if included in your plan)
- Find specific health information
- Learn more about our Quality Management program

Not yet a member?

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

What the plan covers and does not cover

Principal benefits and coverages

Benefits are provided for many of the medically necessary services and supplies needed for care and treatment of sickness and injuries or to maintain good health. Not all services and supplies are covered. Some are covered only to a limited extent and some require precertification and referrals. See "Precertification: Getting approvals for services" and "Referrals: Your PCP may refer you to a specialist when needed" for more. You must access Aetna referred benefits through your selected primary care physician.

Principal services and supplies for which benefits are provided include:

- Primary care physician (PCP) benefits for: Office and hospital visits; Periodic health evaluations, including well-child care, immunizations, routine physical examinations, routine gynecological examinations, and routine cancer, hearing and vision screenings; Injections, including allergy desensitization injections; casts and dressings; and health education counseling and information
- Diagnostic, laboratory and X-ray services
- Specialist physician visits including outpatient and inpatient services
- Direct access specialists visits for: routine gynecological visits and for diagnosis and treatment of gynecological problems; and routine eye examinations
- Maternity care and related newborn care
- Inpatient hospital and skilled nursing facility care
- Non-experimental and non-investigational transplants
- Outpatient surgery
- Substance abuse care (inpatient/outpatient services for detoxification)
- Mental health care
- Pervasive developmental disorders or autism is covered as severe mental illness and/or serious emotional disturbances of a child. Treatment includes, but is not limited to, physical, occupational and speech therapy.
- Emergency and urgent care services
- Outpatient rehabilitation services including: cardiac and pulmonary rehabilitation; and cognitive, physical, occupational and speech therapy
- Home health and hospice care
- Prosthetic and orthotic appliances
- Mastectomy and reconstructive breast surgery
- Other reconstructive surgery
- Limited general anesthesia for dental procedures
- Diabetes treatment
- Phenylketonuria care

Coverage includes but is not limited to all drugs, devices and other products for women as approved by the FDA included within each of the following:

- Sterilization surgery for women
- Surgical sterilization implant for women
- Implantable rod
- IUD copper
- IUD with progestin
- Shot/Injection
- Oral contraceptives (combined pill)
- Oral contraceptives (progestin only)
- Oral contraceptives extended/continuous use
- Patch
- Vaginal contraceptive ring
- Diaphragm
- Sponge
- Cervical cap
- Female condom
- Spermicide
- Emergency contraception (Plan B/Plan B One Step/Next Choice)
- Emergency contraception (Ella)

Terms and conditions of your health plan (such as eligibility, covered benefits, medical necessity, precertification, concurrent review and retrospective record review) are determined at our discretion in accordance with applicable state and federal laws. This means not all services are covered, even if your doctor recommends it. Coverage determinations are subject to review by the Department of Managed Health Care and under certain circumstances may also be eligible for independent medical review.



Principal exclusions and limitations on benefits

Exclusions

The following is a list of services and supplies that are generally not covered:

- Cosmetic surgery
- Custodial care (Note: A member receiving custodial care is entitled to receive medically necessary basic health care services)
- Dental care and dental X-rays
- Donor egg retrieval
- Experimental and investigational procedures (Please see the section, “What to do if you disagree with us” for information about your right to appeal and independent medical review for claims denied because they are considered experimental and investigational)
- Hearing aids
- Home births
- Implantable drugs and certain injectable drugs including injectable infertility drugs unless specifically listed as covered in the Evidence of Coverage
- Infertility services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services unless specifically listed as covered in the Evidence of Coverage
- Non-medically necessary services and supplies
- Orthotics, except as specified in the Evidence of Coverage
- Outpatient prescription drugs and over-the-counter medications and supplies unless specifically listed as covered in the Evidence of Coverage
- Radial keratotomy and related procedures
- Reversal of sterilization
- Special duty nursing
- Rehabilitation therapies when, pursuant to a written treatment plan, it is determined that the therapy is no longer medically necessary

Limitations

If we determine that two or more alternative medical services are equivalent in quality of care, we reserve the right to provide coverage only for the least costly medical service. We make this decision based on medical necessity, so it is subject to independent medical review.

Please see the section, “We check if it’s *medically necessary*” to learn more about medically necessary benefits. See also “What to do if you disagree with us” for information about your right to appeal and to independent medical review for claims denied, limited or delayed due to medical necessity. Determinations about eligibility for benefits, coverage for services, benefit denials and all other terms of the Evidence of Coverage are at our discretion, in accordance with applicable state and federal laws.

Some doctors, hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract that you or your family member might need:

- Family planning
- Contraceptive services, including emergency contraception
- Sterilization, including tubal ligation at the time of labor and delivery
- Infertility treatment
- Abortion

You should call your prospective doctor, medical group, independent practice association or clinic to ensure you can get the health care services you need. Please call Member Services at **1-800-756-7039** for more information about your plan.

No coverage based on U.S. sanctions

If U.S. trade sanctions consider you a blocked person, the plan cannot provide benefits or coverage to you. If you travel to a country sanctioned by the United States, the plan in most cases cannot provide benefits or coverage to you. Also, if your health care provider is a blocked person or is in a sanctioned country, we cannot pay for services from that provider. For example, if you receive care while traveling in another country and the health care provider is a blocked person or is in a sanctioned country, the plan cannot pay for those services. For more information on U.S. trade sanctions, visit www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

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 you could die or risk your health. For a pregnant woman, that includes her unborn child.

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

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

You are covered for emergency care

You have emergency coverage while you are traveling or if you are near your home. That includes students who are away at school.

Sometimes you don't have a choice about where you go for care, like if you go to the emergency room for chest pain after a car accident. When you need care right away, go to any doctor, walk-in clinic, urgent care center or emergency room. When you have no choice, we will pay the bill as if you got network care. You pay your plan's copayments, coinsurance and deductibles for your network level of benefits.

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.

Follow-up care for plans that require a PCP

If you use a PCP to coordinate your health care, your PCP should also coordinate all follow-up care after your emergency. For example, you'll need a doctor to remove stitches or a cast or take another set of X-rays to see if you've healed. Your PCP should coordinate all follow-up care. You will need a referral for follow-up care that is not performed by your PCP. You may also need to get approval if you go outside the network.

After-hours care – available 24/7

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

Prescription drug benefit

Check your plan documents to see if your plan includes prescription drug benefits.

Some plans encourage generic drugs over brand-name drugs

A generic drug is the same as a brand-name drug in dose, use and form. They are FDA approved and safe to use. Generic drugs usually sell for less; so many plans give you incentives to use generics. That doesn't mean you can't use a brand-name drug, but you'll pay more for it. You'll pay your normal share of the cost, and you'll also pay the difference in the two prices.

You may benefit financially to use certain drugs

Some plans pay a larger share for drugs listed on the Aetna Preferred Drug Guide (also known as a "drug formulary"). This guide shows which prescription drugs are covered on a preferred basis. It also explains how we choose medications to be in the guide.

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

Notwithstanding anything contained in this paragraph, using prescription drugs listed in the Aetna Preferred Drug Guide does not include the provision of bonuses and gratuities.

Drug companies may give us rebates when our members buy certain drugs

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

Any payment of rebates to your employer by Aetna will not impact, in any way, the outpatient prescription drug copayment, coinsurance, deductible, limitation and exclusion requirements described in your benefit plan design.

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

Mail-order and specialty drug services are from pharmacies that Aetna owns. These pharmacies are called Aetna Rx Home Delivery and Aetna Specialty Pharmacy, which are for-profit pharmacies.

You might not have to stick to the preferred drug guide

Sometimes your doctor might recommend a drug that's not in the preferred drug guide. If it is medically necessary for you to use that drug, you, someone helping you or your doctor can ask us to make an exception. Your pharmacist can also ask for an exception for antibiotics and pain medicines. Check your plan documents for details.

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

Step therapy shall not apply to pharmaceutical products received through home health, a physician’s office, a hospital or other facility.

Some drugs are not covered at all

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

Get a copy of the preferred drug guide

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

Pediatric asthma supplies

The following pediatric asthma supplies are covered if medically necessary with a prescription from your doctor and when purchased at a participating retail or mail-order pharmacy. You must pay a separate copayment for each item.

- Inhaler spacers
- Peak flow meters

Nebulizers, including face masks and tubing, are covered under the durable medical equipment benefit, which appears in the medical portion of your plan.

In an emergency situation, or when you are traveling outside of the plan’s service area, prescriptions for inhalers will be covered even if filled at a nonparticipating retail pharmacy. You can also get a nebulizer outside the network in an emergency situation.

Always talk to your treating doctor if you have questions about specific medications.

Have questions? Get answers.

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

Mental health and addiction benefits

Plans cover treatment for mental disorders that constitute severe mental illnesses (SMI) and serious emotional disturbances of a child (SED) as defined within the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Your plan documents may also list coverage for treatment of any mental condition identified as a “mental disorder” in the DSM. Mental health benefits are covered on the same basis and are payable in the same amounts as any other illness.

Coverage for Pervasive Developmental Disorder is defined as: *Professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism.*

Please review your Evidence of Coverage for specific coverage provisions, limitations and costs.

Mental health care services are managed by Aetna. Aetna is responsible for, in part, making initial coverage determinations and coordinating referrals to providers. As with other coverage determinations, you may appeal adverse mental health care coverage determinations in accordance with the terms of your health plan.

Accessing mental health care providers

HMO plan members must use therapists and other mental health professionals who are in the Aetna network, unless your needs for covered services are not available within the network.

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

- Call **911** if it’s an emergency.
- Where required by your plan, call your PCP for a referral to the designated behavioral health provider group.
- Call the toll-free Behavioral Health number on your Aetna ID card.
- Call Member Services if no other number is listed.
- Employee Assistance Program (EAP) professionals can also help you find a mental health specialist.

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

Get information about using network therapists

We want you to feel good about using the Aetna network for mental health services. Visit www.aetna.com/docfind and click the “Quality and Cost Information” link. No Internet? Call Member Services instead. Use the toll-free number on your Aetna ID card to ask for a printed copy.

Transplants and other complex conditions

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

Breast reconstruction benefits

Women's Health and Cancer Rights Act of 1998

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

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

Other charges

What you pay

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

- **Copay** – A set amount (for example, \$25) you pay for 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.
 - **Inpatient hospital copay** – This copay applies when you are a patient in a hospital.
 - **Emergency room copay** – 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.
- **Coinsurance** – Your share of the costs of a covered service. Coinsurance is calculated as a percentage (for example, 20 percent) of the allowed amount for the service. For example, if the health plan's allowed amount for an office visit is \$100 and you've met your deductible, your coinsurance payment of 20 percent would be \$20. The health plan pays the rest of the allowed amount.

- **Deductible** – 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 all services. Other deductibles may apply at the same time.

Your costs when you go outside the network

HMO, Aetna HealthFund® HMO, PrimeCare Physicians Plan, Aetna ValueNetworkSM, Vitalidad Mexico con AetnaSM and Aetna Basic HMO plans

These "network-only" plans generally cover health care services only when provided by a doctor who participates in the Aetna network. Your primary care provider (PCP) or specialist may refer you to an out-of-network doctor. You may also go outside the network (when precertified by Aetna) if the services you need are not available within the network. In these cases, your share of the costs will be the same as if you received care within the plan's network.

Otherwise, if you receive services from an out-of-network doctor or other health care provider, you will have to pay all of the costs for the services. See "Emergency and urgent care and care after office hours" for more.

QPOS plans

You may choose a doctor in our network with or without a PCP referral. You may also choose to visit an out-of-network doctor. We cover the cost of care based on your choices.

"**Referred**" benefits means you must get a PCP referral to network doctors to receive the highest level of benefits for specialty care. (See the "Referrals" section for more about this.) If you don't get a referral, your benefit will be paid at the "nonreferred" level. This is the same level of benefits as if you went to an out-of-network doctor.

"**Out of network**" means 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 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 the plan doesn't "recognize." You'll also pay higher 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 you are fully responsible for paying everything above the amount the plan allows for a service or procedure.

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

You can call Member Services at the toll-free number on your Aetna ID card to find out the method your plan uses to reimburse out-of-network doctors. You can also ask for an estimate of your share of the cost for out-of-network services you are planning. The way of paying out-of-network doctors and hospitals applies when you *choose* to get care out of network. See “Emergency and urgent care” to learn more.

If you receive a bill for covered services

Doctors and other health care providers who participate in the network will submit claims for you, so you shouldn't get a bill. However, if you do, or if you go outside the network (when allowed by the plan), you'll need to send the bill to us for payment. Be sure to clearly mark your Aetna member number on the bill.

Send the bill to the address shown on your Aetna ID card. We will make a decision on the claim. For urgent care claims and pre-service claims, we will notify you in writing of our determination.



How we pay your doctors and other health care providers

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

Participating providers in our network are compensated in various ways:

- Per individual service or case (fee for service at contracted rates)
- Per hospital day (per diem contracted rates)
- Capitation (a prepaid amount per member, per month)
- Through Integrated Delivery Systems (IDS), Independent Practice Associations (IPA), Physician Hospital Organizations (PHO), Physician Medical Groups (PMG), behavioral health organizations and similar provider organizations or groups. Aetna pays these organizations, which in turn may reimburse the physician, provider organization or facility directly or indirectly for covered services. In such arrangements, the group or organization has a financial incentive to control the cost of care.

One of the purposes of managed care is to manage the cost of health care. Incentives in compensation arrangements with physicians and health care providers are one method by which Aetna attempts to achieve this goal.

We reward doctors for quality care

In some regions, we pay PCPs extra for quality care and services. These additional payments are typically based on the scores received on one or more of the following measures of the PCP's office:

- Member satisfaction
- Percentage of members who visit the office at least annually
- Medical record reviews
- The burden of illness of the members who have selected the primary care physician
- Management of chronic illnesses like asthma, diabetes and congestive heart failure
- Whether the physician is accepting new patients
- Participation in our electronic claims and referral submission program

Some regions may use some different measures designed to enhance physician performance or improve administrative efficiency. We encourage you to ask your doctor and other providers how we pay them for their services.

Choice of physicians and providers

You can check right now to see if your doctor is in the network

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

Existing members: Visit www.aetna.com and log in. From your secure member website home page, select "Find a Doctor" from the top menu bar and start your search.

Considering enrollment: Visit www.aetna.com and scroll down to "Find a doctor, dentist, facility or vision provider" from the home page. You'll need to select the plan you're interested in from the drop-down box.

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

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

Facilities

Use DocFind as described above or call **1-800-756-7039** for a list of participating provider offices and other health care facilities.

Get a FREE printed directory

To get a free printed list of doctors and hospitals, call the toll-free number on your Aetna ID card. If you're not yet a member, call **1-800-756-7039**.

Choose a primary care physician (PCP)

With an HMO plan, you must choose and receive services from a PCP. With a QPOS plan, you are covered at different levels depending on whether you visit your chosen primary care provider (PCP) or if you go directly to any licensed physician without seeing your PCP first. You can choose any primary care provider who participates in the Aetna network and who is accepting new patients.

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

PCPs for women and children

A female member may choose an Ob/Gyn as her PCP. You may also choose a pediatrician for your child(ren)'s PCP. These doctors acting as your PCP will provide the same services and follow the same guidelines as any other PCP. He or she will issue referrals to other doctors (if your plan requires referrals). He or she will also get approvals you may need and comply with any treatment plans you are on. See the sections about referrals and recertification for more information.

Tell us who you chose to be your PCP

Each member of the family may choose a different PCP from the Aetna network. Enter the name of the PCP you have chosen on your enrollment form. Or, call Member Services after you enroll to tell us your selection. You may change your selected PCP at any time.

If your doctor leaves the Aetna network

If your doctor or other health care provider leaves the network, you may be able to continue to see that doctor during a transitional period. This program is for those who are in an active course of treatment for an acute condition, serious chronic condition, pregnancy, terminal illness, the care of a child, and previously scheduled surgery or other procedures. For information on continuing your care in these situations, please refer to your Evidence of Coverage or call Member Services at the toll-free number on your ID card.

Your health care plan uses the HMO, Aetna HealthFund HMO, QPOS, PrimeCare Physicians Plan, Aetna Value Network, Vitalidad Mexico con Aetna and Aetna Basic HMO provider networks. Throughout this disclosure brochure, references to "participating providers" or "network" refer to providers and facilities in the HMO, Aetna HealthFund HMO, QPOS, Aetna Value Network, SIMNSA Network for the Vitalidad Mexico con Aetna, Aetna Basic HMO or PrimeCare Physicians Plan networks.

Some doctors, hospitals and other health care providers may be contracted with us under different networks. But they are considered nonparticipating if they do not specifically participate in the network your plan uses.

Getting referrals and other plan permissions

Referrals: Your PCP may refer you to a specialist when needed

To receive the highest level of benefits under the plan, you will need to get a referral from your PCP before you can see a network specialist. A “referral” is a written request for you to see another doctor. Some doctors can send the referral right to your specialist for you. There’s no paper involved.

Talk to your doctor to understand why you need to see a specialist. And remember to always get the referral before you receive the care.

Remember these points about referrals:

- You do not need a referral for emergency care.
- If you do not get a referral when required, you may have to pay the bill yourself. If your plan lets you go outside the network, the plan will pay it as an out-of-network benefit.
- Your specialist might recommend treatment or tests that were not on the original referral. In that case, you may need to get another referral from your PCP for those services.
- Women can go to an Ob/Gyn without a referral. See “Direct access Ob/Gyn program” for more.
- Referrals are valid for one year as long as you are still a member of the plan. Your first visit must be within 90 days of the referral issue date.

Referrals within physician groups

Some PCPs are part of a larger group of doctors. These PCPs will usually refer you to another doctor within that same group. If this group cannot meet your medical needs, you can ask us for a coverage exception to go outside this group. You may also need to precertify these services. And you may need permission from the physician group as well.

Standing referrals

If you have a condition that requires ongoing care from a specialist, you may request a standing referral from your PCP or Aetna to such a specialist. A standing referral allows your specialist to continue treating you for up to 12 months. See your Evidence of Coverage for details.

QPOS members can get care without a referral

Under QPOS plans, a member may directly access nonparticipating providers without a PCP referral, subject to cost sharing requirements. Even so, you may be able to reduce your out-of-pocket expenses considerably by using participating providers. Refer to your specific plan brochure for details. If your plan does not specifically cover self-referred or nonparticipating provider benefits (such as an HMO plan) and you go directly to a specialist or hospital without a referral, you must pay the bill yourself. Exceptions include emergency and urgent care and services that are specifically identified as a “direct access” benefit in your plan documents.

Direct access Ob/Gyn program

This program allows women to visit any participating obstetrician or gynecologist for a routine well-woman exam, including a Pap smear, and for obstetric or gynecologic problems. Ob/Gyns may also refer a woman directly to other participating health care providers for covered obstetric or gynecologic services. Precertification requirements apply. If your Ob/Gyn is part of an Independent Practice Association (IPA), a Physician Medical Group (PMG), an Integrated Delivery System (IDS) or a similar organization, your care must be coordinated through the IPA, the PMG or similar organization and the organization may have different referral policies.

All hospitals may not be considered participating for all services

Your doctor can call us to identify a participating hospital for your specific needs.

Certain PCPs are affiliated with Integrated Delivery Systems, Independent Practice Associations (IPA) or other provider groups. If you select one of these PCPs, you’ll generally be referred to specialists and hospitals within that system, association or group. However, if your medical needs extend beyond the scope of the group, you may request coverage for services provided by non-affiliated network specialists and hospitals. In order to be covered, you may have to get prior approval from us and/or the group. See the “Precertification” section for details about getting approvals.

You should note that other specialists may be affiliated with other providers through different organizations. We may pay these organizations or their affiliated doctors through a capitation arrangement or other global payment method. The organization then pays the treating provider directly through various methods. You should ask your provider how he or she is paid for providing health care services to you and if he/she has any financial incentive to control costs.

Precertification: Getting approvals for services

Sometimes we will pay for care only if we have given an approval before you get it. We call that “precertification.” You usually only need precertification for more serious care like surgery or being admitted to a hospital. When you get care from a doctor in the Aetna network, your doctor gets precertification from us. 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 precertification. If you don’t, you will have to pay for all or a larger share of the cost for the service. Even with precertification, you will usually pay more when you use out-of-network doctors.

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

You do not have to get precertification for emergency services.

What we look for when reviewing a request

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

Precertification does not verify if you have reached any plan dollar limits or visit maximums for the service requested. So, even if you get approval, the service may not be covered.

Our review process after precertification (Utilization Review/Patient Management)

We have developed a patient management program to help you access appropriate health care and maximize coverage for those health care services. In certain situations, we review your case to be sure the service or supply meets established guidelines and is a covered benefit under your plan. We call this a “utilization review.”

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

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



Premiums, enrollment and eligibility

Your group is responsible for paying premiums

If you are required to contribute to the premium, your group will tell you the amount and how to pay it (such as payroll deduction).

Renewal provisions: Plans renew each year

The initial term of the plan is usually for a period of one year. Each subsequent term will be for a period of one year unless the plan terminates as provided for in the group agreement. We may change premiums under the plan as of any renewal date upon 30 days prior written notice.

We may modify benefits during the plan year

We may change, reduce or eliminate benefits during the term of the plan as specifically provided under the terms of the group agreement or upon renewal. The revised benefit(s) will apply for services or supplies furnished on or after the effective date of the modification. There is no vested right to receive the benefits of the plan.

Domestic partners and their dependents are eligible to enroll

References to “spouses” and “dependents” also include domestic partners and dependents of domestic partners. You and your domestic partner will need to complete and sign a Declaration of Domestic Partnership with the California Secretary of State. Contact your employer for the form.

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

When you lose your other coverage

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

When you have a new dependent

Getting married? Having a baby? A new dependent changes everything. And you can change your mind. You can enroll within 31 days after a life event if you chose not to enroll during the normal open enrollment period. Life events include:

- Marriage
- Birth
- Adoption
- Placement for adoption

Talk to your benefits administrator for more information or to request special enrollment.

You may choose to leave the plan

If you elect coverage under another health plan, your coverage terminates automatically at the time and date the alternate coverage becomes effective. Your coverage terminates at midnight on the last day of the month during which we receive your notice of intent to disenroll.

Individual continuation of benefits

If you are no longer eligible for the plan

You may be eligible to convert to individual coverage if you are no longer eligible for your group coverage or if you enroll in COBRA, Cal-COBRA or USERRA continuation coverage and then lose eligibility for that coverage. See your Evidence of Coverage for details and conditions. You must apply for conversion within 63 days of the date your group coverage ends.

If you leave the plan

You may be entitled to continue coverage under certain circumstances when coverage would otherwise terminate. The federal law pertaining to this continuation of benefits is the Consolidated Omnibus Reconciliation Act ("COBRA"). COBRA applies to employers with 20 or more eligible employees. The California state law is the California Benefits Replacement Act ("Cal-COBRA"). Cal-COBRA applies to California small employers with fewer than 20 eligible employees. Many of the provisions of COBRA and Cal-COBRA are the same.

COBRA and Cal-COBRA continuation coverage give employees and their dependents whose group plan would otherwise end the opportunity to continue the same group plan for a period of time, usually 18, 29 or 36 months for COBRA; 36 months for Cal-COBRA. Members who have exhausted continuation coverage under COBRA (if continuation coverage is for less than 36 months) have the opportunity to continue coverage for up to 36 months under Cal-COBRA. You have this right if you lose your job or have working hours reduced (other than for gross misconduct). Dependents also have this right to continued coverage if their member spouse dies or they get divorced, or cease to be a dependent child.

You can read more about COBRA and Cal-COBRA in your Evidence of Coverage.

A member who is totally disabled on the date the plan ends will have coverage continued for that disability. Coverage continuation will end at the earlier of: the member's disability ends, covered benefits are exhausted, member's coverage under another plan, or 12 months.

Termination of benefits

We may terminate or not renew coverage for nonpayment of premium

Termination may occur even if you are hospital confined or undergoing treatment for an ongoing condition. We will provide at least 30 days advance written notice of termination. The plan contract will be cancelled, rescinded or not renewed if we do not receive the premium amount by the last day of the grace period.

Coverage may also terminate for other reasons including, but not limited to: terminating employment or losing group membership, obtaining coverage under an alternative health plan offered by the employer or group, or moving out of the service area. If your coverage is terminated for fraud or material misrepresentation in enrollment or in the use of services or facilities, you will receive at least a 30-day written notice of termination.

What to do if you disagree

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.

- You should file your complaint as soon as possible after you receive notice that your health plan enrollment or subscription will be rescinded, canceled or not renewed.
- If your problem is urgent, we must give you a decision within three days. Your problem is urgent if there is a serious threat to your health that must be resolved quickly.
- If your problem is not urgent, we must give you a decision within 30 days.

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

Here are four ways you can file a complaint

1. Call Member Services to file a verbal complaint or to ask for the address to mail a written complaint. Use the phone number on your Aetna ID card or call **1-800-756-7039**.
2. Use our online grievance form located **www.aetna.com/individuals-families/member-rights-resources/Complaints,Grievances,Appeals/California.html**.
3. Send an e-mail to Member Services through the secure member website (Aetna Navigator)
4. Write to us at:
Aetna Health of California Inc.
Attn: Commercial Grievance & Appeals
P.O. Box 24030
Fresno, CA 93779

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.

Take your complaint to the California Department of Managed Health Care (DMHC)

If you have a complaint, you should first call us and use our grievance process before contacting the department. Using this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you.

The DMHC oversees HMOs and other health plans in California and protects the rights of HMO members. You can file a complaint with the DMHC if:

- You are not satisfied with our decision about your complaint.
- You have not received the decision within 30 days or within three days if the problem is urgent.

You may be able to submit a complaint directly to the DMHC, even if you have not filed a complaint with your health plan, if the DMHC determines your problem requires immediate review.

You can download a DMHC complaint form at www.healthhelp.ca.gov.

For help contact:

Help Center, DMHC
980 Ninth St., Suite 500
Sacramento, CA 95814-2725
1-888-466-2219
TDD: **1-877-688-9891**
Fax: **1-916-255-5241**
www.healthhelp.ca.gov

There is no charge to call. Help is available in many languages.

You may call the department if you need help with a complaint involving an emergency, a complaint that we have not satisfactorily resolved or a complaint that has remained unresolved for more than 30 days. You may also be eligible for an Independent Medical Review (IMR). The IMR process provides an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatment that are experimental or investigational in nature and payment disputes for emergency or urgent medical services.

You can call the Department toll-free at **1-888-HMO-2219** (TDD: **1-877-688-9891**) or visit www.hmohelp.ca.gov for complaint forms, IMR application forms and instructions online.

Binding arbitration

Binding arbitration is a way to solve disputes, disagreements or problems without filing a formal lawsuit. Any dispute arising from or related to health plan membership will be determined by binding arbitration and not by a lawsuit or resorting to court process except as California law provides for judicial review of arbitration proceedings.

The agreement to arbitrate includes but is not limited to, disputes involving alleged professional liability or medical malpractice. That is, whether any medical services covered by the plan were unnecessary or were unauthorized or were improperly, negligently or incompetently rendered. This agreement also limits certain remedies and may limit the award of punitive damages. You understand that you are giving up your constitutional rights to have any such dispute decided in a court of law before a jury and instead are accepting the use of binding arbitration. See the sections “Binding Arbitration” and “Limitations on Remedies of the Evidence of Coverage” for further information.

You can get a second opinion

You and/or your doctor can request a second opinion to be provided by an appropriately qualified health care professional if:

- You question the reasonableness or necessity of recommended surgical procedures.
- You question a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function or substantial impairment including, but not limited to, a serious chronic condition.
- The clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or your treating doctor is unable to diagnose the condition, and you’d like an additional diagnosis.
- The treatment plan in progress is not improving your medical condition within an appropriate period of time given the diagnosis and plan of care, and you ask for a second opinion regarding the diagnosis or continuance of the treatment.
- You have attempted to follow the plan of care or have serious concerns about the diagnosis or plan of care after discussing with your doctor.

If you or your treating doctor requests a second opinion, we will provide an authorization or denial as quickly as possible. When your condition poses an imminent and serious threat to your health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or lack of timeliness would be detrimental to your ability to regain maximum function, the second opinion will be authorized or denied in a timely fashion appropriate for the nature of your condition, not to exceed 72 hours after we receive the request whenever possible.

For more information about second opinions, you may contact Member Services at the toll-free telephone number on your Aetna ID card.

Knowing what is covered

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

We check if it's "medically necessary"

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

The product or service:

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

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

If we deny coverage, we'll send you and your doctor a letter. The letter will explain how to appeal the denial. You have the same right to appeal if a physicians' group denied coverage. You can call Member Services to ask for a free copy of the materials we use to make coverage decisions. Or visit www.aetna.com/about/cov_det_policies.html to read our policies. Doctors can write or call our Patient Management department with questions. Contact Member Services either online or at the phone number on your Aetna ID card for the appropriate address and phone number.

You can avoid unexpected bills. Check your plan documents to see what's covered before you get health care. Can't find your plan documents? Call Member Services to ask a specific question or have a copy mailed to you.

We study the latest medical technology

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

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

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

We publish our decisions in our Clinical Policy Bulletins.

We post our findings on www.aetna.com

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

CPBs help us decide whether to approve a coverage request. Your plan may not cover everything our CPBs say is medically necessary. Each plan is different, so check your plan documents.

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

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

Member rights and responsibilities

Know your rights as a member

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

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

Making medical decisions before your procedure

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

There are three types of advance directives:

- Durable power of attorney – 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 you don’t want CPR if your heart stops or a breathing tube if you stop breathing.

You can create an advance directive in several ways:

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

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

Learn about our quality management programs

We make sure your doctor provides quality care for you and your family. To learn more about these programs, go to our website at www.aetna.com. Enter “commitment to quality” in the search bar. You can also call Member Services to ask for a printed copy. The toll-free number is on your Aetna member ID card.

We protect your privacy

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

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

Summary of the Aetna Privacy Policy

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

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

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

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

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

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

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

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

Anyone can get health care

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

We must comply with these laws:

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

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

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

Register as an organ, eye and tissue donor

More than 12.3 million people in California are registered as organ, eye, and tissue donors. However, only 39 percent of the eligible state population is registered. There are more than 123,000 people in the national organ transplant waiting list, and more than 22,000 individuals in California.

Unfortunately, 22 people die each day because an organ did not become available. The need for organ donors is critical.

A single donor can help as many as 50 individuals in need of organs or tissues. In California, consent (first-person or by the family) is given in approximately 80 percent of cases in which the patient met the criteria for donation. Medical suitability for donation is determined at the time of death.

If you would like to help save lives, please take the following steps:

- 1 Indicate your interest to be an organ and tissue donor. Register at the DMV or online at donatelifecalifornia.org.
- 2 Call Donate Life California at **1-866-797-2366** for a free brochure on donation.
- 3 Most importantly, discuss your decision to donate with family members and loved ones.

Donate Life California is proud to partner with the four organ procurement organizations in the state; Donor Network West, Lifesharing, One Legacy and Sierra Donor Services to fulfill our mission to save lives by inspiring people to sign up with the state organ, eye and tissue donor registry.

Fast facts about organ donation

- The decision to be an organ donor does not affect the quality of medical care you will receive.
- Donation does not disfigure the body or interfere with funeral plans, including open casket services.
- All major religions support or permit organ, eye and tissue donation.
- Anyone, regardless of age or medical history, can sign up on the Donate Life California Registry.

Health benefits plans are offered by Aetna Health of California Inc.

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 is believed to be accurate as of the production date; however, it is 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 list of health plans and their NCQA status can be found on the NCQA website located at <http://reportcard.ncqa.org>.

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

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

See “Other Reports on Health Care Quality” in the drop-down menu for Managed Behavioral Healthcare Organizations – for behavioral health accreditation and Credentials Verifications Organizations – for credentialing certification.

If you need this material translated into another language, please call Member Services at 1-888-982-3862.

Si usted necesita este material en otro lenguaje, por favor llame a Servicios al Miembro al 1-888-982-3862.