



Ready, set, know

Aetna OfficeLink Updates™ All regions

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OfficeLink Updates™ (OLU) is going digital

We're moving OLU into the digital age! Instead of postcard notifications, you will get email reminders to tell you that OLU is available online at aetna.com.

To keep you up to date on all the important information included in this newsletter, we need your email address. Just sign up on **NaviNet®**, our secure provider website, before January 31, 2018. It's easy: in the "Workflows for This Plan" menu on Aetna Plan Central, choose "Email Options" and then "Share Email Address."

Remember, OLU comes out in March, June, September and December, so be sure to look for us in your inbox.

CORRECTION: The June 2017 newsletter incorrectly stated that the stool DNA test (FIT-DNA) for colorectal cancer is reimbursed only for Medicare members. The test is reimbursed for all members (commercial and Medicare).



aetna.com

Updates to our national precertification list

Changes to our National Participating Provider Precertification List

These changes to the National Participating Provider Precertification List (NPL) will take effect as noted below.

Reminders

We encourage you to submit precertification requests at least two weeks before the scheduled services.

The following new-to-market drugs require precertification effective September 1, 2017:

- Haegarda (C1 Esterase Inhibitor Subcutaneous [Human]). This drug is included in the hereditary angioedema drug class.
- Mavyret (glecaprevir/pibrentasvir) and Vosevi (sofosbuvir/velpatasvir/voxilaprevir). These drugs are included in the hepatitis C drug class.
- Renflexis (infliximab-abda) and Tremfya (guselkumab). These drugs are included in the immunologic agents drug class. Precertification for the site of care is also required for Renflexis.

The following new-to-market drug requires precertification effective September 26, 2017:

- Fibryna (fibrinogen, human). This drug is included in the blood-clotting-factor drug class.

The following new-to-market drug requires precertification effective November 3, 2017:

- Besponsa (inotuzumab ozogamicin)

The following new-to-market drug requires precertification effective November 10, 2017:

- Kymriah (tisagenlecleucel)



You can find more information about precertification under the “General Information” section of the NPL.

Start submitting all of your precertification requests electronically



Did you know that in 2018, electronic* precertification requests will become our new standard? That's right — when you submit an electronic precertification request, you never have to worry about calling the correct number or waiting on hold. Submitting precertification requests online is faster and easier than calling. And you submit electronic requests on your schedule, not ours.



How to get started

To submit electronic precertification requests, pick a vendor from our [list of approved vendors](#). Or [register](#) for and use [NaviNet®](#), our secure provider website. You don't even have to be participating to register or to use the site. But if you're participating, you can access administrative tools on the site.



Upload documents electronically

Soon we'll be introducing a way for you to upload documents electronically through our secure provider website. If you've had to fax documentation to us in the past, you'll be able to send it to us electronically. Look for future announcements by email and on [aetna.com](#).



We're here to help

We offer live [webinars](#) to teach you how to submit precert requests electronically. Follow the instructions in the "How to Register for Webinars" section to register. Or you can [email us for help](#).

*In accordance with Medicare regulations, we'll continue to accept precertification requests initiated telephonically for members enrolled in Medicare plans.

New precertification requirement effective March 1, 2018

Effective March 1, 2018, we'll require precertification for outpatient Computerized Axial Tomography (CAT) scan procedures for the **Delaware, Pennsylvania** and **southern New Jersey** markets. Precertification won't be required for patients in emergency departments. We're doing this to:

- Keep providing access to improved quality care
- Ensure that we approve coverage only when providers perform procedures according to current evidence-based guidelines that national professional associations develop

How to precertify

- Call eviCore at **1-888-693-3211**. Fax to **1-844-822-3862**, Monday through Friday, during normal business hours or as required by federal or state regulations.
- Go to [evicore.com](#).

You can review eviCore healthcare criteria at [evicore.com/resources/pages/providers.aspx#ReferenceGuidelines](#).

Since eviCore handles the precertification process, please don't call us for approval for these services.

We're here to help

If you have questions about these changes, call eviCore at **1-888-693-3211**. Or call us at:

- **1-800-624-0756** for HMO-based and Medicare Advantage benefits plans
- **1-888-MDAetna (1-888-632-3862)** for all other plans.



Clinical payment, coding and policy changes

We regularly adjust our clinical payment and coding policy positions as part of our ongoing policy review processes. Our standard payment policies identify services that may be incidental to other services and, therefore, ineligible for payment. In developing our policies, we may consult with external professional organizations, medical societies and the independent Physician Advisory Board, which advises us on issues of importance to physicians. The chart below outlines coding and policy changes.

Procedure	Effective date	What's changed
Expanded claims editing*	March 1, 2018	<p>We're expanding our claims editing capabilities by adding a new third party claims editing solution. This will allow us to enhance our prepayment claims editing processes for clinical payment and coding policy rules. Also, this will improve accuracy for existing edits and add new claims edits.</p> <p>The claims editing solution is based on guidelines such as:</p> <ul style="list-style-type: none">• The Centers for Medicare & Medicaid Services medical coverage, payment and coding policies• The American Medical Association Current Procedural Terminology (CPT®) coding standards• Evidence-based guidelines from nationally recognized professional health care organizations and public health agencies <p>Check secure provider website for information</p> <p>You'll have access to a new prospective claims editing disclosure tool available on our <u>secure provider website</u>. After you log in, go to Plan Central > Aetna Claims Policy Information > Policy Information > Expanded Claims Edits to determine if our new claim edits will apply to your claim.</p> <p>We expect these added claims edits to increase the accuracy of claims. Our goal is to have fewer claims resubmissions and overpayment refund requests.</p>
Multiple procedure reduction for diagnostic cardiology services*	March 1, 2018	<p>On March 1, 2018, we will begin reducing the allowable amount of multiple diagnostic cardiology services by 25 percent.</p> <p>This change does not apply to the service with the highest relative value units (RVU) rate.</p> <p>This change applies to the technical component (TC) of the RVU only, for:</p> <ul style="list-style-type: none">• Services on the same date of service• Services billed by a single provider• Services billed for the same patient

Procedure	Effective date	What's changed
Multiple procedure reduction for diagnostic ophthalmology services*	March 1, 2018	<p>On March 1, 2018, we will begin reducing the allowable amount of multiple diagnostic ophthalmology services by 20 percent.</p> <p>This change does not apply to the service with the highest RVU rate. This change applies to the TC of the RVU only, for:</p> <ul style="list-style-type: none"> • Services on the same date of service • Services billed by a single provider • Services billed for the same patient
Multiple procedure reductions for therapy services	March 1, 2018	<p>Reminder: We apply multiple procedure reductions to certain therapy services. We pay 100 percent of the therapy service the highest practice expense (PE) RVU. We reduce the PE RVU portion of the total RVU by 50 percent for more therapy services performed on the same day.</p>
Correct coding of hospital observation, critical care, and admission and discharge services*	December 1, 2017	<p>In September, we told you that, effective December 1, 2017, we would limit coverage for hospital professional services to once per day, per patient across all providers. We decided that we won't apply the policy to critical care services (99291-99292). Also, we won't apply the policy to hospital admission services (99221-99223) for nonparticipating providers for our Medicare Advantage plans.</p>
Payment and coding policy changes*	March 1, 2018	<p>Our standard payment policies do not reimburse services that we consider incidental to the overall episode of care. This includes supplies, materials and equipment such as:</p> <ul style="list-style-type: none"> • Sutures or suture substitutes • Dressings • Syringes • Gauze • Catheters • Guide wires • Stationary devices • Parenteral infusion pumps <p>Starting March 1, 2018, the Healthcare Common Procedure Coding System (HCPCS) codes C2617, C2625, C1752, C1769, C1770, C2623 and C1884 will be considered incidental. There will be no additional payment for these items.</p>

*Washington state providers: This item is subject to regulatory review and separate notification.

Reminder: Management and Network Services LLC (MNS) contract ends January 1, 2018

Effective January 1, 2018, MNS won't be a contracted provider. It will no longer coordinate the skilled nursing services for credentialing or manage authorizations or claims payments. This change impacts all patients enrolled in Aetna and/or Coventry Medicare and in commercial or network access business (First Health®, auto or workers' compensation) lines of business.

Send future claims submissions electronically or by mail

For dates of service on or after January 1, 2018, please submit all patient claims directly to Aetna and/or Coventry. Just check the back of the member's ID card for the correct address or claims-payer ID number.

Changes to commercial drug lists begin on April 1, 2018

On April 1, 2018, updates will be made to our pharmacy plan drug lists. Starting on January 1, 2018, you can view the list of upcoming changes on our **Formularies & Pharmacy Clinical Policy Bulletins** page. Changes to the Aetna Standard Plan will be available in February 2018.

Reminder:

- Effective January 1, 2018, a maximum daily dose of up to 90 morphine milligram equivalent (MME) will be implemented for all opioid-containing medications used for the treatment of pain.
- The use of opioids in the treatment of acute pain will be limited to a seven-day maximum duration of therapy.
- If required, additional quantities may be requested through the medical exception process. Refer to "Ways to request a drug prior authorization" in the next column.

Want to select a preferred drug for your patient from your cell phone? Our commercial formulary is available for mobile devices. Just go to the App Store® or Google Play™ store and type in "Formulary Search" — then download the Formulary Search app for free.*

You can also search at **formularylookup.com**. Enter the drug name, state and channel (plan type). Then under "Payer/PBM," select "Aetna Inc." to view the drug coverage information. At the bottom of the page, you can select "Download on the App Store" to access this information on your phone.*

These changes will affect all Pharmacy Management drug lists, precertification, quantity limits and step-therapy programs.

Ways to request a drug prior authorization:

1. Call the Aetna Pharmacy Precertification Unit at **1-855-240-0535**.
2. Fax your completed **Prior Authorization Request Form** to **1-877-269-9916**.
3. Submit your completed request form through our **secure provider website**.

For more information, call the Aetna Pharmacy Management Provider Help Line at **1-800-238-6279 (1-800-AETNA RX)**.

*Google Play and the Google Play logo are trademarks of Google Inc. App Store is a service mark of Apple Inc. registered in the U.S. and other countries.

Contraceptive Services Payment program

What you need to know

The Contraceptive Services Payment program is only for members of reproductive age. A qualifying group health plan or student health insurance covers the program. Coverage applies to any female dependents also covered under the medical plan.

Claims submission

You'll need to submit claims for covered contraceptive services under the ID card number found on these cards. Claims should be submitted using payer number 60054.

ID cards and ID numbers

Below is a sample of the ID card that members in this program should use when getting covered contraceptive services. The ID number on these ID cards is specific to this program. It's not the same ID number used on standard member ID cards. The words "Contraceptive Services Payment Program" will be on these cards.

Providers can access member ID cards electronically. Log in to our secure provider website at aetna.com.



If you have questions about member-specific benefits and cost-sharing information, call the number on the back of the ID card.

Systems update affects Aetna DirectSM National Advantage Program (NAP) providers

We want to let providers who are part of Aetna Direct NAP know about a systems update. As of July 2017, when we deny claims as mutually exclusive or incidental, they'll now correctly be recorded as provider nonbillable.

You should not balance bill members for these claims. These denials will now accurately show as contractual write-offs and not as member liabilities.

Complete patient health assessments before the year's end

It's out with the old and in with the new — as in the New Year. It's fast approaching. A common goal for the New Year is better health. Now is the time to reach out to those patients who haven't taken advantage of their health assessment benefit. Remind them how important an annual health assessment can be.

Patients enrolled in an individual or a small group plan, either on or off the health insurance exchange, are eligible for an annual assessment.

Heads up to all Risk Adjustment Functional Tier (RAFT) participants

Remember, you must complete all health assessments by **December 31, 2017**, for them to count toward your total RAFT score. Also, don't forget to submit a claim with comprehensive ICD codes for any existing medical conditions identified in the health assessment.

We appreciate your efforts. You're helping to achieve our common goal of creating a healthier population.

We're here to help

If you have any questions, just contact your embedded nurse educator. Or call us at **1-855-777-5425**.

Office news

Aetna Signature Administrators® and Government Employees Health Association (GEHA) are expanding their relationship once again

Starting **January 1, 2018**, GEHA members living in Alaska will begin accessing the Aetna Signature Administrators® preferred provider organization (PPO) program and medical network nationally.

This expanded relationship is expected to result in approximately 168,000 total members seeking care nationally.

GEHA is the second-largest national health association serving federal employees, federal retirees and their families. It provides health benefits plans to more than 1 million members worldwide.

Remember, GEHA members in the states listed to the right are currently accessing Aetna Signature Administrators nationally.

Contact your local Aetna PPO network account manager if you have any questions.

- | | |
|-----------------|-----------------|
| • Arizona | • Nevada |
| • California | • New Hampshire |
| • Connecticut | • New Jersey |
| • Florida | • New York |
| • Georgia | • Oregon |
| • Kentucky | • Pennsylvania |
| • Maine | • Rhode Island |
| • Massachusetts | • Vermont |
| • Michigan | • Washington |

Reminder: Send Aetna Signature Administrators® (ASA) claims to the correct payer

Keep these tips in mind when submitting claims for ASA members:

- Know that not all members using our network are set up to have their claims come directly to us.
- Send ASA claims electronically (**with the exception of transplant services***) to the correct payer ID as shown on the back of the member's ID card.
- Send paper claims only to the address listed on the ID card.

Claims questions and rework

Direct all ASA claims questions to the appropriate payer on the ID card. The payer will process the claims and contact us as needed.

Recognizing ASA members

The ID card generally has two logos:

- The payer's logo
- The Aetna Signature Administrators logo:

**Aetna Signature
Administrators®**

Alaska members can soon use the ASA program and network

Starting January 1, 2018, Government Employees Health Association (GEHA) members living in Alaska can use the ASA preferred provider organization program and medical network nationally.

For more information about ASA, see our [**flyer**](#).

*The exception is when an ASA member accesses one of our Institutes of Excellence™ facilities for transplant services. In this scenario, the facility will use the Special Case Customer Service Unit for submitting claims.

Our Office Manual keeps you informed

Our Office Manual for Health Care Professionals is available on our website. For Innovation Health, once on the website, select “Health Care Professionals,” then “Practice Resources.”

Visit us online to view a copy of your provider manual as well as information about:

- Our adopted clinical practice guidelines and preventive services guidelines, which address preventive, acute and chronic medical and behavioral health services. Find them on our secure provider website. Select “Clinical Resources” from the Aetna Support Center.
 - Policies and procedures
 - Patient management and acute care
 - Our complex case management program (members referred through multiple avenues; learn how to refer them)
 - How to use disease management services and how we work with your patients in the programs
 - Special member programs and resources, including the Aetna Women’s HealthSM program, Aetna Compassionate CareSM and others
 - Member rights and responsibilities
 - How we make utilization management decisions based on coverage and appropriateness of care. Information includes our policy against financial compensation for denials of coverage.
 - Medical records criteria — a detailed list of elements we require to be documented in a patient’s medical record is available in the **Office Manual for Health Care Professionals**
 - The most up-to-date **Aetna Medicare Preferred Drug Lists**, **Commercial (non-Medicare) Preferred Drug Lists** and the **Consumer Business Preferred Drug List** (also known as our formularies)
- Also visit us online for information on how our quality management program can help you and your patients. We integrate quality management and metrics into all that we do. Find details on the program goals and our progress online.
- If you don’t have Internet access, call our Provider Service Center for a paper copy of this information.

The following message is from our lab partner Quest Diagnostics®

Genetic testing resource — with the power of genetic insights

At Quest Diagnostics, we’re committed to helping you improve the health of your patients. As a preferred network lab for Aetna, we can also help lower patients’ out-of-pocket costs. And we offer convenient access to a broad test portfolio designed to meet the diverse needs of your patients.

In addition, we deliver a comprehensive array of genetic testing and related services, which include:

- A leading portfolio of more than 3,500 tests, from routine to advanced genetic and molecular testing
- Professional consultation from more than 700 staff MDs, PhDs and genetic counselors

Talk to your sales representative or visit us online at **QuestDiagnostics.com/Physicians/Genetics** to learn more. There are advantages when testing with the leading national provider of innovative diagnostic services. We have:

- 700+ genetic tests
- 40+ years of genetic testing experience
- 3 genomic centers of excellence

You can also call us at **1-866-GENE-INFO (1-866-436-3463)** to speak with a board-certified medical geneticist or genetic counselor.

How to update data about your office

To update your office's demographic information, go to our **secure provider website** and sign in. You should notify us whenever the following information changes:

- Email and mailing addresses
- Phone or fax numbers
- Name changes due to marriage or another life event
- Whether your office is accepting new patients
- Hospital and group affiliations

If you've been calling our Provider Service Center to make these changes, we ask you to use the secure provider website instead. The site lets you confirm the information you submit. It also prevents unauthorized individuals from submitting incorrect information about your office or facility.

The Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage plans and Qualified Health Plans (QHPs) to maintain accurate directories. Having your up-to-date information allows us to do that.

Electronic transactions

You also can do most electronic transactions through the secure provider website. This includes submitting claims, checking patient benefits and eligibility, and requesting precertifications.

NaviNet security officers have access to Aetna's "Update Provider Demographics" function, through which they can submit demographic changes. They also can authorize other users' access to this feature as appropriate. To use the secure website, you must **register** first.

New referral message now in effect

Our policy is that all referrals must be to providers that participate in a member's specific benefits plan. To clarify our rejection process, we've implemented a new additional denial message. The message informs the referring provider that the referred-to provider is not participating in the member's benefits plan.

The new message reads:

The referred-to provider ID utilized is not participating in this member's specific network. Resubmit using a different referred-to provider ID. Access the Aetna website in the Healthcare Professionals section to find a participating provider for this member's plan.



Medicare

New fraud prevention initiative to stop identify theft



Personal identity theft affects a large and growing number of seniors. People age 65 or older are increasingly the victims of this type of crime. This is why the Centers for Medicare & Medicaid Services (CMS) is starting a fraud prevention initiative that removes Social Security numbers from Medicare cards. The aim is to help combat identity theft and safeguard taxpayer dollars.

CMS will mail new Medicare ID cards starting in April 2018

Starting April 2018, CMS will begin mailing new Medicare cards, which will include a new Medicare number. The mailings will be staggered throughout the year, with completion expected by April 2019. The new Medicare number will take the place of the HICN on Medicare cards. The new Medicare number won't change Medicare benefits. Once Medicare members get the new card, they should destroy their old card and start using the new card right away.

Where to find more information

You can find more information on the [CMS site](#). Please take a minute to familiarize yourself with the upcoming new Medicare card changes. We're asking you to help prepare people with Medicare for this change.

Balance billing of Qualified Medicare Beneficiary (QMB) individuals is prohibited

The QMB program is a Medicaid program for Medicare beneficiaries that exempts them from being charged for Medicare cost sharing.

State Medicaid programs may pay providers for Medicare deductibles, coinsurance and copayments. However, federal law allows states to limit provider reimbursement for Medicare cost sharing under certain circumstances. Dually eligible individuals may qualify for Medicaid programs that pay Medicare Part A and B premiums, deductibles, coinsurance and copays to the extent provided by the state Medicaid plan.

Medicare providers **must** accept the Medicare payment and Medicaid payment (if any) as payment in full for services to a QMB individual. Medicare providers who violate these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions.

Clarifications about balance billing

Be aware of these policy clarifications to help ensure compliance with QMB balance billing requirements:

- All Original Medicare and Medicare Advantage providers — not only those that accept Medicaid — must abide by the balance-billing prohibitions.
- QMB individuals retain their protection from balance billing when they cross state lines to receive care. Providers can't charge QMB individuals even if their QMB benefit is provided by a state that is different from the one where care is rendered.

More information

For more information about dual eligible categories and benefits, visit CMS's [Medicare-Medicaid General Information](#) website. For more on the QMB program and other individuals dually eligible for Medicare and Medicaid benefits, see the Medicare Learning Network® publication [Dual Eligible Beneficiaries Under the Medicare and Medicaid Programs](#).

Don't let your network status change — complete your FDR attestation today

If you are a participating provider in our Medicare plans and/or our Medicare-Medicaid plans (MMPs), you must meet the Centers for Medicare & Medicaid Services (CMS) compliance program requirements for first-tier, downstream and related (FDR) entities. You also have to confirm your compliance with these requirements through an annual attestation.

How to complete your attestation

You'll find the resources you need to ensure your compliance on the **Medicare Compliance Attestation page** of [aetna.com](https://www.aetna.com). Once on the page, click "See Our Medicare Compliance Program Guide" or "See Our Office Manual" under "Need More Information."

Once you review the information and ensure that you've met the requirements, you're ready to complete your attestation. Simply click the link on the Medicare Compliance Attestation page that corresponds to your contracting status. A single annual attestation meets all your Aetna, Coventry and/or MMP compliance obligations.

Where to get more information

If you have compliance-related questions not addressed in our guide, just call us at **1-800-624-0756**. If you're an MMP-only provider, you can email us at medicaidmmpfdr@aetna.com. You'll find more information in our quarterly **FDR Compliance Newsletter**, too.



Skilled nursing coverage based on patient need

Do you have patients who might need skilled nursing care? If so, here's some important information you and your staff will need to know.

The Centers for Medicare & Medicaid Services (CMS) clarified that Medicare enrollees are eligible for skilled nursing and therapy services based on their need for such care. Services include care in a skilled nursing facility or in a home health or outpatient therapy setting.

A patient's prospects for improvement should not be part of the coverage decision.

Focus on need for services

CMS notes it has never endorsed an "improvement standard" for these services. Rather, coverage for skilled care depends on an assessment of the person's medical condition and the reasonableness and necessity of the care. The care is covered if it helps the person safely and effectively maintain a practical level of day-to-day function.

An insurer may deny coverage if it believes the care is unnecessary. But it must explain its denial in detail.

More information for your staff

This information is relevant to your office staff involved in billing for skilled nursing care. CMS offers more details [here](#).

Pharmacy

Important pharmacy updates

Medicare

Visit our [Check Our Medicare Drug List](#) web page to view the most current Medicare plan formularies (drug lists) that we update at least annually.

For a paper copy of the formularies, call **1-800-414-2386**.

Commercial — notice of changes to prior authorization requirements

Visit our [Formularies & Pharmacy Clinical Policy Bulletins](#) web page to view:

- Commercial pharmacy plan drug guides with new-to-market drugs that we add monthly
- Clinical Policy Bulletins with the most current prior authorization requirements for each drug



State-specific articles

California

How to access your fee schedule

In accordance with the regulations issued pursuant to the Claims Settlement Practices and Dispute Mechanism Act of 2000 (CA AB1455 for HMO) and to the expansion of the Health Care Providers Bill of Rights (under CA SB 634 for indemnity and PPO products), we're providing you with information about how to access your fee schedule.

- If you're affiliated with an Independent Practice Association (IPA), contact your IPA for a copy of your fee schedule.
- If you're directly contracted with Aetna, you can call our Provider Service Center for help with up to ten current procedure terminology® (CPT®) codes. For requests of eleven or more codes, you can enter the codes on an Excel spreadsheet (include tax ID, contact telephone number, CPT and modifier) and email them to us at feeschedule@aetna.com.
- If your hospital is reimbursed through Medicare Groupers, visit the [Medicare](#) website for your fee schedule information.

Maryland

How to ID providers no longer in the network

Maryland Insurance Code 15-112 — Provider Panels requires Aetna to notify primary care physicians (PCPs) of the termination of a specialty referral services provider. To comply, we offer access to the Maryland Provider Terminations (Quarterly Report). This report lists specialists in health maintenance organization (HMO)-based plans whose participation in Aetna's network terminated during the specified time frame.

You can find this [report](#) in our [Office Manual for Health Care Professionals](#). Review the report periodically to see which providers no longer participate with us.

To view a current listing of providers who participate in our network, go to our [Provider Online Referral Directory](#). Referring your Aetna members to in-network providers helps them control their out-of-pocket costs.

If you have questions about the Aetna network or making specialty referrals to in-network providers, contact our Provider Service Center at **1-800-624-0756**.

New Jersey

Where to find our appeal process forms

We have updated the information about internal and external **provider appeal processes** on our public website.

If you use the **NJ Health Care Provider Application to Appeal a Claims Determination form** when submitting certain claims appeals, you should make sure your claim is eligible. You can find this form and the correct procedures on our public website.

Pennsylvania

New gold ID cards for PEBTF/REHP HMO plan members

Now it's easier to help your Pennsylvania Employees Benefit Trust Fund (PEBTF) and Retired Employees Health Program (REHP) patients get the best coverage they can. We created a new health maintenance organization (HMO) **Gold ID Card** to help you identify which of the **two different Aetna health plans** they have — preferred provider organization (PPO) or HMO.

The main difference between plans is that your **HMO plan patients must be referred to their network provider** to be covered. You'll recognize them by their new gold ID card.

PPO plan

- **WHITE** member ID card
- Broad network
- Does not require referrals



HMO plan

- **GOLD** member ID card
- Clinically integrated (narrow) network
- Requires referrals to **PEBTF/REHP Custom HMO plan-designated providers** for coverage
- If you're not a provider in this network, your participation in other Aetna health plans won't change



To find providers in the PEBTF/REHP HMO network:

- Visit our **Provider Online Referral Directory**.
- Select a provider type, select your area, then click "Search."
- From the "Select a Plan" menu, under "Customer Specific Plans," select PEBTF/REHP Custom HMO.

If you have any questions, you can call us at **1-800-624-0756**.

The sample ID cards above may not exactly illustrate final representations.

Texas

We offer a new plan in the Dallas-Fort Worth market

Aetna and Texas Health Resources have established a jointly owned health plan called Texas Health AetnaSM.

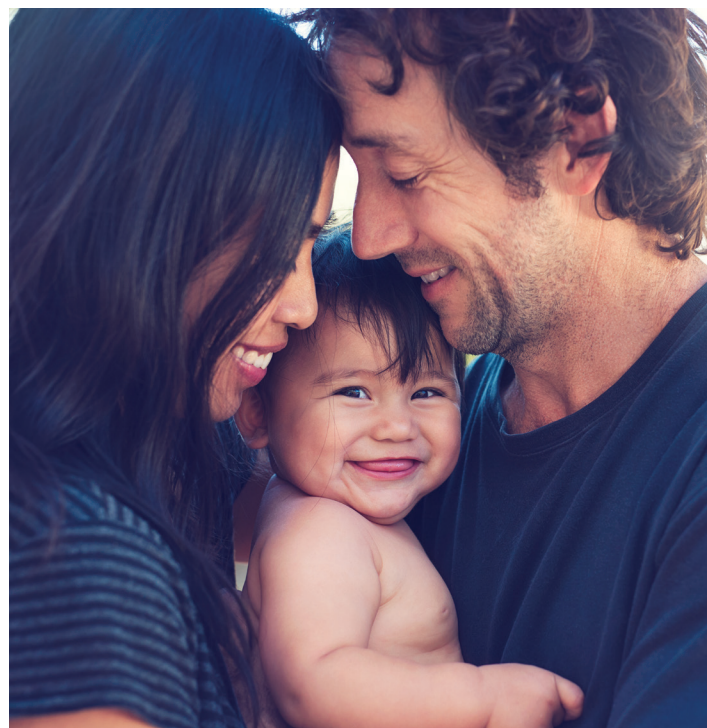
The plan is available to employer groups based primarily in the Dallas-Fort Worth area. You should verify eligibility before seeing a member in Texas Health Aetna. Some plan options under Texas Health Aetna offer a limited network. Not all Aetna providers are part of this network.

Aetna administers the Texas Health Aetna planSM. This means Aetna policies and procedures apply to their members. Here are some things you should know:

- Your Aetna fee schedule applies to these members unless you signed a direct contract with Texas Health Aetna.
- Texas Health Aetna members have their own ID card.
- You should submit claims using payer ID 88221 and use the address on the back of the member ID card.

Use the Aetna **secure provider website** for online transactions and tools for Texas Health Aetna, as well as to access member ID cards. For more information:

- Visit the **Texas Health Aetna** website
- Call the number on the Texas Health Aetna member's ID card



Washington

New credentialing service for Washington practitioners

The Washington legislature enacted HB 2335 earlier this year. This bill affects the way health carriers like us must access the state-licensed health care practitioner credentialing application in Washington state.

Effective **June 1, 2018**, HB 2335 requires that health carriers use the ProviderSource database developed by OneHealthPort to accept and manage all credentialing applications from Washington health care providers.

Currently, we use the Council for Affordable Quality Healthcare® (CAQH®) ProView as the source for getting application data needed to complete the credentialing and recredentialing process. To comply with this legislation, as of June 1, 2018, we must only use ProviderSource to get this data. This means that Washington state licensed practitioners will no longer be able to use CAQH ProView after that date.

What you need to do to comply

We ask that you enter your credentialing data in **ProviderSource** as soon as possible so we can continue to access it.

Washington

Look for a new network name on some members' cards

Soon, you may see members with Aetna ID cards listing the Washington Value Network. This is a new network we're offering to plan sponsors, including the Washington Education Association.

Check the DocFind® online provider directory if you are not sure of your participation status in this network. The network is searchable as "(WA) Washington Value Network." Members covered by this network have no out-of-network benefits. So if you are not in this new network, your services will not be covered under the members' plan.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).

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