UW Medicine Contract Renewal Frequently Asked Questions

What is happening between Aetna and UW Medicine?

Our network agreement with UW Medicine ended and as of June 1, 2025, they are no longer part of our Commercial and Medicare Advantage health plan networks. However, we are continuing our contract discussions in hopes of reaching a fair agreement and bringing them back into our networks.

Why didn't Aetna and UW Medicine come to an agreement.

For more than 6 months, we have worked to reach an agreement with UW Medicine that is fair to our members and keeps their facilities and providers in our networks. Unfortunately, they have continued to insist on rate increases that would burden our members and plan sponsors with significant cost increases. That is why we weren't able to reach an agreement.

Is it likely that Aetna and UW Medicine will sign a new agreement?

We are hopeful that our continuing discussions with UW Medicine will result in an agreement that is fair to our members and plan sponsors and brings their facilities and providers back into our health plan networks.

What happens if members continue receiving care from UW Medicine providers that are no longer part of their health plan network?

Members that continue receiving care from a provider that is no longer part of their health plan network would pay more out of pocket than when the provider was in network. The amount depends on whether their health plan covers services from providers not in their plan's network.

Generally, members pay less out of pocket when they use providers in their plan's network. We recommend members check their health plan details before seeing a provider not in their plan's network to understand their costs.

Does this affect members with an Aetna Medicare Supplemental plan?

No, Aetna Medicare Supplemental plans are not impacted by this renewal. With a Medicare Supplemental plan, members may see any provider that accepts Medicare at their current coverage level.

Can members still use UW Medicine emergency rooms?

Yes. For life-threatening injuries or illnesses, members should go to the nearest hospital emergency room immediately. Emergency services are covered at their plan's in-network benefit level. Any other charges they may be responsible for will be determined by their health plan.

Do members need to take any action if they have a planned procedure or are undergoing treatment with UW Medicine.

Members that have a scheduled procedure or are receiving an active course of treatment from a UW Medicine facility or provider should call the Member Services number on their member ID card to get a Transition of Care (TOC) request form for their doctor to fill out.

Transition of Care coverage can apply when a member's doctor or facility leaves the plan's network. Approved TOC coverage allows a member who is receiving treatment to continue the treatment from their current provider for a limited time at the highest plan benefits level.

What is an active course of treatment?

An active course of treatment means that you have begun a program of planned services with your doctor to correct or treat a diagnosed condition. Some active course of treatment examples may include, but are not limited to, members who:

- Are pregnant and have begun a course of treatment (including pre-natal care) for the pregnancy from the obstetrician (OB) or facility.
- Are undergoing a course of treatment for a serious and complex condition from the provider or facility, such as chemotherapy or radiation therapy.
- Are or was determined to be terminally ill (if the individual has a medical prognosis that the individual's life expectancy is 6 months or less) and is receiving treatment for such illness from such provider or facility.
- Need more than one surgery, such as cleft palate repair.
- Have recently had surgery.
- Are being treated for a mental illness or for substance abuse. (The member must have had at least one treatment session within 30 days before the status of the member or the participating health care provider changed.)
- Have an ongoing or disabling condition that suddenly gets worse.
- May need or have had an organ or bone marrow transplant.
- Are scheduled to undergo non-elective surgery from the provider, including receipt of post-operative care from such provider or facility with respect to such a surgery.

To be considered for TOC coverage, treatment must have started before the date your doctor or facility left the health plan's network or the before the date a doctor or facility's network status changed.

How long does TOC coverage last?

Usually, TOC coverage lasts 90 days, but this may vary based on the member's condition (for example pregnancy). We will tell members if their TOC coverage request is approved and how long the coverage will last.

How do members sign up for TOC coverage?

Members can get a TOC request form by calling the Member Services number on the back of their ID card.

TOC requests must be submitted to the health plan within 90 days of the date the health care provider left the plan's network or within 90 days from the date on the letter notifying the member of the change. The member or their doctor can send in the request form.

What if I have more questions about TOC coverage?

Call the Member Services number on the back of your member ID card.