Important disclosure information about Traditional and PPO based plans

Table of contents

2268201-18-02 (4/25)

Here is important disclosure information about our plans. It's followed by required content that varies by state.

We offer quality health plans

By following health plan accreditation standards of the National Committee for Quality Assurance (NCQA), we offer you quality health plans. Visit **https://www.aetna.com/content/dam/aetna/pdfs/aetnacom/individuals-families-health-insurance/document-library/documents/plan-disclosures/NCQA-MED-Dsclsr-FI-SI.pdf** to learn more about how we meet the NCQA accreditation and standards. You can also call us at the number on your member ID card to ask for a printed copy.

This document details how to:

Understand your health plan

- Benefits and services included in, and excluded from, your coverage
- Prescription drug benefit
- Mental health and addiction benefits
- Care after office hours, urgent care, and emergency care

Get plan information online and by phone

- How you can reach us
- Help for those who speak another language and for the hearing impaired
- Get information about how to file a claim
- Search our network for doctors, hospitals and other health care providers
- Accountable care organizations (ACOs)
- Our quality management programs, including goals and outcomes

Know the costs and rules for using your plan

- What you'll pay
- Your costs when you go outside the network
- Precertification: getting approvals for services
- We study the latest medical technology
- How we make coverage decisions
- Complaints, appeals and external reviews

Understand your rights and responsibilities

- Member rights and responsibilities
- Notice of Privacy Practices

Features of a traditional or preferred provider organization (PPO)-based plan

If you're a member, not all of the information in this document applies to your specific traditional or PPO-based plan. Most information applies to all plans, but some does not. For example, not all plans have prescription drug or behavioral health benefits. There's also information that may only apply to a handful of states and plans. To be sure about which plan features apply to you, check your Summary of Benefits and Coverage plan documents. Can't find them? Ask your benefits administrator or call Member Services to have a copy of your plan documents mailed to you.

How some plans pay

Providers set the rates to charge you. It may be higher (sometimes, much higher) than what your Aetna® plan allows. For some plans, your doctor may bill you for the dollar amount that the plan doesn't allow and no dollar amount above the allowed charge will count toward your deductible or out-of-pocket limits. This means you're fully responsible for paying everything above the amount the plan allows for a service or procedure. However, emergency care is always covered by your plan, and you don't have to get prior approval.

2268201-18-02 (4/25)

innovation HEALTH®

Plans pay for your health care depending on the plan that you, or your employer, chooses. Some plans pay for services by looking at what Medicare would pay and adjusting that amount up or down. Plans range from paying 90% of Medicare (that is 10% less than Medicare would pay) up to 300% of Medicare (the Medicare rate multiplied by three). Some plans pay for services based on what is called the "usual and customary" charge. 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 number on your member ID card to find out the method your plan uses to pay providers.

Not yet a member?

For help understanding how a certain medical plan works, review the plan's Summary of Benefits and Coverage document.

Avoid unexpected bills

To avoid a surprise bill, make sure you check your plan documents to see what's covered before you get health care. Also, make sure you get care from a provider who is part of your plan's network. This just makes sense because:

- We have negotiated lower rates for you
- Network doctors and hospitals won't bill you above our negotiated rates for covered services
- You have access to quality care from our national network

To find a network provider, sign in to **InnovationHealth.com** and select "Find a Doctor" from the top menu bar to start your search. To learn more about how we pay out-of-network benefits when a plan allows them, visit **InnovationHealth.com** and type "how we pay" into the search box.

Get a free printed directory

To get a free printed list of doctors and hospitals, call the toll-free number on your member ID card. If you're not yet a member, call **1-888-982-3862 (TTY: 711)**.

Choose a primary care physician (PCP)

Most traditional or PPO-based plans don't require you to select a PCP. However, some employers may require you to do so. We strongly encourage you to choose one because your PCP can help coordinate your care and order tests and screenings. If it's an emergency, you don't have to call your PCP first. You may change your PCP at any time.

Members may choose an Ob/Gyn as their PCP. Ob/Gyns acting as your PCP will provide the same services and follow the same guidelines as any other PCP. You may also be able to choose a pediatrician for your child(ren)'s PCP. See your plan documents for details.

Getting approval for some services

Usually, we will pay for care only if we have given an approval before you get it. Your plan documents list all the services that require you to get prior approval.

First, we check to see that you're still a member. And we make sure the service is 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 solely on the existence of coverage and the appropriateness of care and service, using nationally recognized guidelines. 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 care management programs. If so, one of our nurses may contact you. Precertification doesn't verify whether 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.

No coverage, based on financial sanctions

Complying with financial sanctions laws and regulations is a top priority. If applicable sanctions, laws and regulations, such as those under the Department of Treasury's Office of Foreign Assets Control ("OFAC"), consider you a "designated person," the plan cannot provide benefits or coverage to you. Likewise, traveling to a U.S. sanctioned location (e.g. Cuba) for medical treatment, in most cases, will prohibit benefits or coverage. These regulations also apply if your health care provider is a designated person or is located in a sanctioned location. For more information, visit: **Treasury.gov/resource-center/sanctions/pages/default.aspx**.

Coverage for transplants

Our National Medical Excellence Program® (NME) is for members who need a transplant. 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.

What does "medically necessary" mean?

It 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 to see if you have one. It might also be to treat an injury or illness. The product or service must be ordered by your doctor and:

- 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 symptom
- Can't be just for the member's or the doctor's convenience
- Can't cost more than another service or product that is just as effective

Only medical professionals can decide if a treatment or service isn't medically necessary. We don't reward our employees for denying coverage. If we deny coverage, we'll send you and your doctor a letter. It'll explain why we denied treatment and how you can appeal the denial.

Clinical policy bulletins

We write a report about a product or service when we decide if it's medically necessary. We call the report a clinical policy bulletin (CPB). CPBs guide us in deciding 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 visit **Aetna.com/health-care-professionals/clinical-policy-bulletins.html** to read CPBs. No internet? Call the number on your Aetna member ID card and ask for a copy of a CPB for any product or service.

What to do if you disagree with us

If you disagree with something we've done, you can talk to us on the phone. Or you can mail us a written complaint. The phone number is on your Aetna member ID card. You can also email us at **Aetna.com**.

Still not satisfied?

You can file an appeal

Did we deny your claim? Directions on how to appeal our decision are in:

- The letter we sent you
- The Explanation of Benefits statement that says your claim was denied

The letter we sent you tells you:

- What we need from you
- How soon we will respond

2268201-18-02 (4/25)

innovation HEALTH®

If a denial is based on a medical judgment, you may be able to get an external review if you're not satisfied with your appeal once you complete the entire internal appeal process. Some states have their own external review process, and you may need to pay a small filing fee to your state. In other states, external review is available but follows federal rules.

For help or to learn more:

- Go to **USA.gov/state-tribal-governments** and select your state's website.
- Call the phone number on your member ID card.

You can contact an independent review organization (IRO)

An IRO will assign your case to one of its experts. The expert will be a doctor or other professional who specializes in the area referred to in your case or in your type of appeal. You should have a decision within 45 calendar days of the request. The IRO's decision is final and binding; we will follow its decision and you won't have to pay anything, unless there was a filing fee.

You can get a rush review

If your doctor thinks you cannot wait 45 days, ask for an expedited review. That means we will make our decision as soon as possible.

Member rights and responsibilities

We don't consider race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national origin when giving you access to care. Federal law requires network providers to do the same.

Nondiscrimination policy for genetic testing

We don't use the results of genetic testing to discriminate, in any way, against applicants or enrollees. Also, you choose if you want to tell us your race or ethnicity and preferred language. We'll keep that information private. We use it to help us improve your access to health care and to serve you better.

Your rights under the Employee Retirement Income Security Act of 1974 (ERISA)

If you're a participant in an employer-funded group health plan, you're entitled to certain rights and protections under ERISA. Some of those rights are listed below. Your rights are outlined in more detail in your plan documents.

Below are some of your rights.

- Receive, free of charge, information about your plan and benefits.
- Upon written request to your plan administrator, examine copies of documents governing the operation of the plan, contracts, collective bargaining agreements, annual reports and more. The administrator may charge you a reasonable copy fee.
- Receive a copy of procedures used to determine a qualified domestic relation or medical child support order.
- Continue group health coverage for you, your spouse or dependents if there is a loss of coverage as the result of a qualifying event.
- Know why a claim was denied.
- Exercise your rights and take steps to enforce your rights, without discrimination or retribution.
- Get answers to your questions about the plan. Contact your plan administrator with questions about your plan. If they don't provide the information you asked for, you can get help from the nearest office of the Employee Benefits Security Administration, which is part of the U.S. Department of Labor. Look them up online or in your local telephone directory.

2268201-18-02 (4/25)

innovation HEALTH®

Women's Health and Cancer Rights Act of 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under WHCRA. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema

Benefits will be provided to a person who has already undergone a mastectomy as a result of breast cancer while covered under a different health plan. Coverage is provided according to 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. Or follow these links to learn more.
Fact sheet from the U.S. Department of Health and Human Services: **https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet.html**
Pamphlet from the U.S. Department of Labor: **https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/your-rights-after-a-mastectomy.pdf**

Your right to enroll later

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? If you chose not to enroll during the normal open enrollment period, you may enroll within 31 days after a life event. Examples of life events are marriage, divorce, birth, adoption, and placement for adoption. Talk to your benefits administrator for more information or to request special enrollment.

Important information for certain states and plans

Here is additional disclosure content that varies by state.

Virginia

Virginia service area

The Virginia service area includes the following cities and counties:

Cities

Alexandria

Fairfax

Falls Church

Fredericksburg

Manassas

Manassas Park

Winchester

Counties

Arlington

Clarke

Fairfax

Fauquier

2268201-18-02 (4/25)

Frederick

Loudoun

Page

Prince William

Shenandoah

Spotsylvania

Stafford

Warren

Get a review from someone outside Innovation Health

If the denial of your claim is due to a medical judgment, you may be able to get an outside review if you're not satisfied with your appeal decision.

- For cases related to the treatment of cancer, it's not necessary to complete all internal appeals before getting an outside review.
- For most other cases, you will need to finish all your internal appeals before getting an outside review.

2268201-18-02 (4/25)

TTY: **711**

English	**To access language services at no cost to you, call** 1-888-982-3862 .
Amharic	እርስዎ ወጪ ሳያወጡ የቋንቋ አገልግሎቶችን ለመድረስ ወደ 1-888-982-3862 ይደውሉ።
Arabic	للحصول على خدمات اللغة مجانًا، اتصل على 1-888-982-3862
Armenian	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք հեռախոսահամարով: 1-888-982-3862
Carolinian (Kapasal Falawasch)	ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-888-982-3862 .
Chamorro	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-888-982-3862 .
Chinese Traditional	如欲使用免費語言服務，請致電 1-888-982-3862 .
Cushitic-Oromo	Tajaajila afaanii bilisaan argachuuf, 1-888-982-3862 irratti bilbilaa.
French	Afin d'accéder aux services langagiers sans frais, composez le 1-888-982-3862 .
French Creole (Haitian)	Pou w jwenn aksè ak sèvis lang gratis pou ou, rele 1-888-982-3862 .
German	Um kostenlos auf Sprachdienste zuzugreifen, rufen Sie 1-888-982-3862 an.
Greek	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-888-982-3862 .
Gujarati	તમારે કોઇ તના ખર્ચ વના ભાષાની સેવાઓની પહચ માટે, કોલ કરો 1-888-982-3862 .
Hindi	आपके लए बना कसी कमत के भाषा सेवाआ का उपयोग करने के लए, 1-888-982-3862 पर कॉल करे।
Hmong	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-888-982-3862 .
Italian	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-888-982-3862 .
Japanese	無料の言語サービスをご利用いただくには、1-888-982-3862 にお電話ください。
Karen	လၢကမၤန့ၢ် ကျိာ်တၢ်မၤစၢၤတၢ်မၤ လၢတလိၣ်လက်ဘူၣ်လက်စ့ၤ လၢနဂီၢ်အဂီၢ်, 1-888-982-3862 .
Korean	무료로 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화하세요
Laotian	ເພື່ອເຂົ້າເຖິງການບໍລິການພາສາໂດຍບເສຍຄ່າໃຊ້ຈ່າຍໃດໆແກ່ທ່ານ, ໃຫ້ໂທຫາ 1-888-982-3862 .
Mon-Khmer, Cambodian	ដើម្បីទទួលនេសវាផ្នែកភាសាដោយមិនគិតថ្លៃពីអ្នកសូមទូរសព្ទទេលខ 1-888-982-3862 ។
Navajo	T'áá ni nizaad k'ehjí bee níká a'doowoł doo bą́ąh ílínígóó kojį' hólne' 1-888-982-3862 .
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff 1-888-982-3862 .
Persian-Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-888-982-3862 تماس بگیرید.
Polish	Aby uzyskać bezpłatny dostęp do usług językowych, zadzwoń pod numer 1-888-982-3862 .
Portuguese	Ligue para 1-888-982-3862 para receber assistência linguística gratuita.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-888-982-3862 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Russian	Чтобы получить бесплатные языковые услуги, позвоните по номеру 1-888-982-3862 .
Samoan	Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-888-982-3862 .
Serbo-Croatian	Za besplatne prevodilačke usluge pozovite 1-888-982-3862 .
Spanish	Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862 .
Syriac-Assyrian	ܠܡܛܝܐ ܠܚܠܡܬܐ ܕܬܘܪܓܡܐ ܕܠܫܢܐ ܕܠܐ ܛܝܡܐ ܩܪܝ ܥܠ: ܡܢܝܢܐ، ܗܢܐ 1-888-982-3862 .
Tagalog	Upang ma-access ang mga serbisyo sa wika nang wala kang babayaran, tumawag sa 1-888-982-3862 .
Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-888-982-3862 .
Ukrainian	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-888-982-3862 .
Vietnamese	Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-982-3862 .