Important disclosure information about traditional and PPO-based plans

Innovation Health is the brand name used for products and services provided by Innovation Health Insurance Company. Health benefits and health insurance plans are offered and/or insured by Innovation Health Insurance Company.

Innovation Health Insurance Company is an affiliate of Inova and of Aetna Life Insurance Company and its affiliates (Aetna). Aetna provides certain management services to Innovation Health. Each insurer has sole financial responsibility for its own products.

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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 **Aetna.com/individuals-families-health-insurance/document-library/documents/2019Disclosures/NCQA-MED-Disclosures-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 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.

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.

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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.

Women who are 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 U.S. trade sanctions

If U.S. trade sanctions consider you a "blocked person," the plan can't provide benefits or coverage to you. If you travel to a country sanctioned by the United States, the plan, in most cases, can't provide benefits or coverage to you. Also, if your health care provider is a blocked person or is in a sanctioned country, we can't 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 can't pay for those services. For more information, visit **Treasury.gov/resource-center/sanctions/pages/default.aspx** to read about U.S. trade sanctions.

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Coverage for 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.

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 Aetna employees for denying coverage. If we deny coverage, we'll send you and your doctor a letter. It will explain why we denied the 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 **InnovationHealth.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

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. 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:

- Visit your state's government website at **USA.gov/state-tribal-governments**
- 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.

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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.

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.

For more information:

- Call the number on your member ID card
- Visit the U.S. Department of Labor at **DOL.gov/sites/dolgov/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.

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Important information for certain states and plans

Here is additional disclosure content that varies by state.

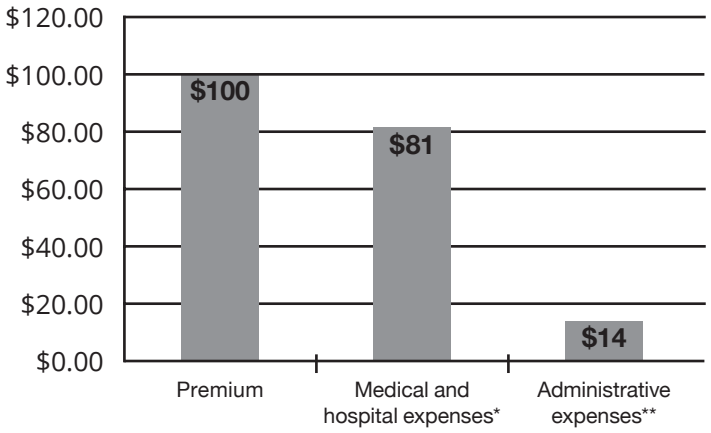
Maryland

How we pay providers

Terms	The example shows how Dr. Jones, an obstetrician gynecologist, would be compensated under each method of payment.	Percentage of physicians paid using this described method
Salary	A physician is an employee of Aetna and is paid compensation (monetary wages) for providing specific health care services. Since Dr. Jones is an employee of Aetna, she receives her usual biweekly salary regardless of how many patients she sees or the number of services she provides. During the months of providing prenatal care to Mrs. Smith, who is a member of Aetna, Dr. Jones' salary is unchanged. Although Mrs. Smith's baby is delivered by Cesarean section, a more complicated procedure than a vaginal delivery, the method of delivery will not have any effect on Dr. Jones' salary.	0%
Capitation	A physician (or group of physicians) is paid a fixed amount of money per month by Aetna for each patient who chooses the physician(s) to be his or her doctor. Payment is fixed without regard to the volume of services an individual patient requires. Under this type of contractual arrangement, Dr. Jones participates in an Aetna network. She is not employed by Aetna. Her contract with Aetna stipulates that she be paid a certain amount each month for patients who select her as their doctor. Since Mrs. Smith is a member of Aetna, Dr. Jones' monthly payment does not change as a result of her providing ongoing care to Mrs. Smith. The capitation amount paid to Dr. Jones is the same whether or not Mrs. Smith requires obstetric services.	5.59%
Fee-for-service	A physician charges a fee for each patient visit, medical procedure or medical service provided. Dr. Jones' contract with the insurer or Aetna states that Dr. Jones will be paid a fee for each patient visit and each service she provides. The amount of payment Dr. Jones receives will depend on the number, types, and complexity of services, and the time she spends providing services to Mrs. Smith. Because Cesarean deliveries are more complicated than vaginal deliveries, Dr. Jones is paid more to deliver Mrs. Smith's baby than she would be paid for a vaginal delivery. Mrs. Smith may be responsible for paying some portion of Dr. Jones' bill.	98%

Terms	The example shows how Dr. Jones, an obstetrician gynecologist, would be compensated under each method of payment.	Percentage of physicians paid using this described method
Discounted fee-for-service	Payment is less than the rate usually received by the physician for each patient visit, medical procedure, or service. This arrangement is the result of an agreement between the payer, who gets lower costs, and the physician, who usually gets an increased volume of patients. Like fee-for-service, this type of contractual arrangement involves Aetna paying Dr. Jones for each patient visit and each delivery; but, under this arrangement, the rate, agreed on in advance, is less than Dr. Jones' usual fee. Dr. Jones expects that in exchange for agreeing to accept a reduced rate, she will serve a certain number of patients. For each procedure she performs, Aetna will pay Dr. Jones a discounted rate.	0%
Bonus	A physician is paid an additional amount over what he or she is paid under salary, capitation, fee-for-service or other type of payment arrangement. Bonuses may be based on many factors, including member satisfaction, quality of care, control of costs and use of services. Aetna rewards its physician staff or contracted physicians who have demonstrated higher than average quality and productivity. Because Dr. Jones has delivered so many babies and has been rated highly by her patients and fellow physicians, Dr. Jones will receive a monetary award in addition to her usual payment.	1%
Case rate	Aetna and the physician agree in advance that payment will cover a combination of services provided by both the physician and hospital for an episode of care. This type of arrangement stipulates how much Aetna will pay for a patient's obstetric services. All office visits for prenatal and postnatal care, as well as the delivery, and hospital-related charges are covered by one fee. Dr. Jones, the hospital, and other providers (such as an anesthesiologist) will divide payment from Aetna for the care provided to Mrs. Smith.	0%

Maryland premium dollar distribution disclosure



The cost of providing health care services in the state of Maryland did not exceed the premium revenue per $100.

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. The complaint and appeal processes can be different depending on your plan and where you live. Some states have laws that include their own processes. But these state laws don't apply to many plans we administer. So it's best to check your plan documents or talk to someone in Member Services to see how it works for you.

Call us to file a verbal complaint or to ask for the appropriate address to which to mail a written complaint. The phone number is on your ID card. You can also email us through the member website. If you're not satisfied after talking to us, you can ask that your issue be sent to the appropriate complaint department.

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 (EOB) statement that says your claim was denied. The letter also tells you what we need from you and how soon we will respond.

For plans in Maryland, you, or your provider acting on your behalf, may file a complaint with the commissioner without first filing an appeal. If the coverage decision involves an urgent medical condition for which care has not been rendered, you can write to:

Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

Telephone number: **1-410-468-2000**
TTY: **1-800-735-2258**
Toll-free: **1-800-492-6116**
Fax: **1-410-468-2270**

The Health Advocacy Unit is available to assist you and/or your provider in both mediating and filing an appeal under the carrier's internal appeals process. You can contact them at:

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 Saint Paul Place, 16th Floor
Baltimore, MD 21202

Telephone number: **1-410-528-1840**
Toll-free: **1-877-261-8807**
Fax: **1-410-576-6571**

Email: **Heau@oag.state.md.us**

*Medical and hospital expenses includes the costs of physician services, other professional services, referrals, emergency room visits and hospitalization.

**Administrative expenses include, but may not be limited to, occupancy, depreciation and amortization, marketing, salaries, interest expense, and accounting and corporate expenses.

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You may request a copy of the Behavioral Health Care Expense Form

As required by Maryland regulation, we must complete and maintain a Behavioral Health Care Expense Form within 90 days after the end of each calendar year. This form is available upon request to an individual, enrollee or member. We may charge a fee of up to $15 plus actual postage and handling.

The Behavioral Health Care Expense Form contains the following information:

- The name of each managed behavioral health care organization with which the carrier has a contract
- The calendar year for which the data are reported
- Total direct payments made by the carrier to each managed behavioral health care organization during the calendar year
- Direct behavioral health care expenses during the calendar year
- Amounts included in direct behavioral health care expenses for quality assurance or utilization management activities or treatment plan reviews
- Behavioral health care administrative expenses during the calendar year
- The name, title, telephone number and signature of the individual completing the form and the date the form was completed

To request a copy of the Behavioral Health Care Expense Form, please call the number on your ID card.

Mental illness, emotional disorders, and drug and/or alcohol use disorder benefits

Contact the Maryland Insurance Administration at the following address for more information about these benefits:

Maryland Insurance Administration
Attn: Consumer Complaint Investigation
Life and Health/Appeals and Grievance
200 Saint Paul Place, Suite 2700
Baltimore, MD 21202

Virginia

Virginia service area

The Virginia service area includes the following cities and counties:

Cities	Counties
Alexandria	Arlington
Fairfax	Clarke
Falls Church	Fairfax
Fredericksburg	Fauquier
Manassas	Frederick
Manassas Park	Loudoun
Winchester	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.

Innovation Health complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call [the number on your ID card] (or) [insert phone number].

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512, **1-800-648-7817, TTY: 711**, Fax: **859-425-3379**, **CRCoordinator@aetna.com**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at **1-800-368-1019, 800-537-7697 (TDD)**.

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TTY: 711

To access language services at no cost to you, call 1-888-982-3862 .

Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862. (Spanish)

如欲使用免費語言服務，請致電 1-888-982-3862 。(Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 1-888-982-3862 . (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-982-3862 . (Tagalog)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-982-3862 an. (German)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-888-982-3862 . (Arabic)

Pou jwenn sèvis lang gratis, rele 1-888-982-3862 . (French Creole-Haitian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-888-982-3862. (Italian)

言語サービスを無料でご利用いただくには、1-888-982-3862 までお電話ください。(Japanese)

무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오. (Korean)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-888-982-3862 تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-888-982-3862 . (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-982-3862 . (Portuguese)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-982-3862 . (Russian)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-982-3862 . (Vietnamese)

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