innovation HEALTH®
Aetna | Inova PARTNERSHIP

Important information about your health benefits — Virginia

For Innovation Health Leap℠ medical insurance plans

https://my.innovation-health.com

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Understanding your plan of benefits

Innovation Health medical benefits plans cover most types of health care from a doctor or hospital, but they do not cover everything. The plan covers recommended preventive care and care you need for medical reasons. It does not cover services you may just want to have, like plastic surgery. It also does not cover treatment that is not yet widely accepted. You should also be aware that some services may have limits. For example, a plan may allow only one eye exam per year.

Where to find information about your specific plan

Your "plan documents" list all the details for the plan you chose. This includes what's covered, what's not covered and what you will pay for services. Plan document names vary. They may include a Policy and Schedule of Benefits and updates that come with them. If you can't find your plan documents, call the toll-free number on your digital member ID card.

Virginia service area

The following counties and cities: Alexandria City, Arlington, Clarke, Fairfax, Fairfax City, Falls Church City, Fauquier, Frederick, Fredericksburg City, Loudoun, Manassas City, Manassas Park City, Page, Prince William, Shenandoah, Spotsylvania, Stafford, Warren and Winchester City.

Get plan information online and by phone

Existing members

If you're already an Innovation Health member, you have two convenient ways to get plan information.

1. **Log in to your secure member website at https://my.innovation-health.com.**
   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 digital member ID card handy to register. Then, visit **https://my.innovation-health.com** and click "Sign Up." Follow the prompts to complete the one-time registration.

   Then you can log in anytime to:

   - Access your digital member ID card
   - 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 provider search tool to find in-network care
   - Learn more about and access any wellness programs that come with your plan

2. **Call the toll-free number on your digital member ID card.**

   You can speak with an advocate to:

   - Understand how your plan works and your share of costs
   - Get information about how to file a claim
   - Find care outside your area
   - File a complaint or appeal
   - Get copies of your plan documents
   - Connect to behavioral health services
   - Find specific health information
   - Learn more about our quality management program

Not yet a member?

You can call us at **1-888-443-1616** if you need help understanding how a particular medical plan works.

Search your plan's network for doctors, hospitals and other health care providers

Use the online provider 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. Access the search tool as follows:

Existing members: Log in to your secure member website at **https://my.innovation-health.com.**

Considering enrollment: Visit **https://buyhealthinsurance.innovation-health.com/?state=VA**.

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

Get a FREE printed directory

To get a free printed list of doctors and hospitals, call the toll-free number on your digital member ID card. If you're not yet a member, call **1-844-289-4503**.

Contact Virginia state officials

If you need to contact someone about this insurance for any reason, you may also contact your agent if you have one. If you have been unable to contact us or your agent or if you are not satisfied with the response, you may contact:

Virginia State Corporation Commission's Bureau of Insurance
Life and Health Division
PO Box 1157
Richmond, VA 23218
Phone: **804-371-9691**
Fax: **804-371-9944**

or

Office of the Managed Care Ombudsman
Bureau of Insurance
PO Box 1157
Richmond, VA 23218
Toll-free phone: **1-877-310-6560**
Richmond metropolitan area: **804-371-9032**
Email: ombudsman@virginia.gov

Written correspondence is preferred so they have a record of your inquiry. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

Innovation Health Insurance Company is regulated as a Managed Care Health Insurance Plan (MCHIP) and as such, is subject to regulation by both the Virginia State Corporation Commission Bureau of Insurance and the Virginia Department of Health.

Help for those who speak another language and for the hearing impaired

If you require language assistance, please call the number on your digital member ID card, and a representative will connect you with an interpreter. You can also get interpretation assistance for utilization management issues or for registering a complaint or appeal. If you're deaf or hard of hearing, use your TTY and dial **711** for the Telecommunications Relay Service. Once connected, please enter or provide the telephone number you're calling.

Ayuda para las personas que hablan otro idioma y para personas con impedimentos auditivos

Si usted necesita asistencia lingüística, por favor llame al número que aparece en su tarjeta de identificación digital para el miembro, y un representante le conectará con un intérprete. También puede recibir asistencia de interpretación para asuntos de administración de la utilización o para registrar una queja o apelación. Si usted es sordo o tiene problemas de audición, use su TTY y marcar **711** para el Servicio de Retransmisión de Telecomunicaciones (TRS). Una vez conectado, por favor entrar o proporcionar el número de teléfono que está llamando.

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 get the service. The amount can vary by the type of service. For example, you may pay a different amount to see a specialist than you would pay to see your family doctor.

Coinsurance — Your share of the costs for a covered service. This is usually a percentage (for example, 50 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 50 percent would be $50. The health plan pays the rest of the allowed amount.

Deductible — The amount you owe for health care services before your health plan begins to pay. For example, if your deductible is $3,000, you have to pay the first $3,000 for covered services before the plan begins to pay. You may not have to pay for some services. Other deductibles may apply at the same time.

Your costs when you go outside the network

We cover the cost of care based on if the health care provider, such as a doctor or hospital, is "in network" or "out of network."

"In network" means we have a contract with that provider. Providers agree to how much they will charge you for covered services. That amount is often less than what they would charge if they were not in our network. Most of the time, it costs you less to use doctors and hospitals in our network. They also agree to not bill you for any amount over their contract rate. All you have to pay is your copayments along with any deductible. Your network provider will handle any precertification required by your plan.

"Out of network" means we do not have a contract for discounted rates with that health care provider. We don't know exactly what an out-of-network provider will charge you. If you choose a provider who is out of network, your Innovation Health 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 provider.

Your out-of-network doctor or hospital sets the rate to charge you. It may be higher — sometimes much higher — than what your Innovation Health plan "recognizes" or "allows." Your doctor may bill you for the dollar amount that 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 that you are fully responsible for paying everything above the amount that the plan allows for a service or procedure.

When you choose to see an out-of-network provider, 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 the toll-free number on your Innovation Health ID card to find out the method your plan uses to reimburse out-of-network providers. You can also ask for an estimate of your share of the cost for out-of-network services you are planning. The method of paying out-of-network doctors and hospitals applies when you *choose* to get care out of network. See "Emergency and urgent care and care after office hours" to learn more.

Going in network just makes sense

- We have negotiated discounted rates for you.
- In-network doctors and hospitals won't bill you for costs above our rates for covered services.
- You are in great hands with access to quality care from our network.

Precertification: getting approvals for services

Sometimes we will pay for care only if we have given an approval before you get the care. 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 network, your doctor gets precertification from us.

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 digital member 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 precertification 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 care 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 our 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.

If you have a chronic condition or an upcoming hospital stay

You may qualify for one of our care management programs. Our nurses can be the extra support you need. After you enroll, just call the number on your ID card to learn more.

Information about specific benefits

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 that 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.
- Tell your doctor 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.

Emergency care is covered

Sometimes, you don't have a choice about where you go for care, like if you go to the emergency room. When you need emergency care, we will pay the bill as if you got care in network. When you get this care from a network provider, you'll only pay your plan's cost-sharing amount. That's your deductible and/or copay.

Also, we may pay less than what an out-of-network provider charges. Don't worry, for an emergency situation, you don't have to pay it. So, if the provider bills you for the rest of the cost, just call us at the number on your digital member ID card, and we'll take care of it.

See your plan documents and the "No coverage based on U.S. sanctions" section in this booklet for more information.

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 at **https://my.innovation-health.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

Innovation Health pharmacy benefits are administered by Aetna. When your doctor prescribes you a drug, then it's time to use your pharmacy coverage. Use it well, and it can save you money. Here's how:

You get best coverage when you use a network pharmacy

You can go to any licensed pharmacy in or out of the network. See your plan documents to find out how much you'll pay.

Find a network pharmacy near you online

Before you fill a prescription, go to your secure member website. There you can find network pharmacies near you. Browse our directory, or you can look them up just like you would a doctor or hospital. See "Search your plan's network for doctors, hospitals and other health care providers" in this booklet for more.

You can look up your drugs and know the costs ahead of time on your secure member website

Just click on "Check Drug Cost." You'll find your cost for each drug by pharmacy. You can also compare the cost at a local pharmacy with your cost for mail order to see how much you can save.

Some plans encourage generic drugs over brand-name drugs

Many brand-name drugs have generic versions with the same active ingredients. Or there may be a different generic drug that can treat your condition. Generic drugs are as safe and effective as their brand-name versions. For certain drugs, you must get the generic. 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.

We may also encourage you to use certain drugs

Some plans encourage you to buy certain prescription drugs over others. The plan may even pay a larger share for those drugs. We list those drugs in the preferred drug guide (also known as a "formulary"). This guide shows which prescription drugs are covered under your plan. It also explains how we choose drugs to be in the guide. When you get a drug that is not covered under your plan, your share of the cost will usually be more.

Get convenient refills through home delivery

Home delivery and specialty drug services are from pharmacies that Aetna owns. Aetna Rx Home Delivery and Aetna Specialty Pharmacy are included in your network and provide convenient options for filling medicine you take every day or specialty medicines that treat complex conditions.

You may have to get approval before some drugs are covered

Sometimes your doctor might recommend a drug that's not covered under your plan. 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 or your doctor can ask for an exception.

You may request an exception for some drugs that are not covered

Your plan documents might list specific drugs that are not covered. Your plan may also not cover drugs that we haven't reviewed yet. You, someone helping you or your doctor may have to get our approval (a medical exception) to use one of these drugs.

Get a copy of the preferred drug list

You can find the preferred drug guide on your secure member website. Or you can call the toll-free number on your digital member ID card to ask for a printed copy. We may add new drugs to the guide. Look online or call the toll-free number on your digital member ID card for the latest updates.

Mental health and addiction benefits

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

- Call **911** if it's an emergency.
- Call the toll-free number on your digital member ID card.

Transplants and other complex conditions

The National Medical Excellence Program® 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 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 National Medical Excellence Program based on their expertise and experience with these services. We also follow any state rules when choosing these hospitals.

Important benefits for women

Women's Health and Cancer Rights Act of 1998

Your Innovation Health health plan provides benefits for all stages of mastectomy and mastectomy-related services, including 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/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet.html**, and the U.S. Department of Labor website, **www.dol.gov/ebsa/consumer_info_health.html**.

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**.

How we determine what's covered

Avoid unexpected bills. Check your plan documents to see what's covered before you get health care. Can't find your plan documents? Call the toll-free number on your digital member ID card to ask a specific question or have a copy mailed to you.

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. Or it might 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 our employees for denying coverage. Sometimes a physician's 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 physician's group denied coverage.

You can call the toll-free number on your member ID card to ask for a free copy of the materials we use to make coverage decisions. Doctors can write or call our Patient Management department with questions. Contact us either online or at the phone number on your member ID card for the appropriate address and phone number.

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 https://my.innovation-health.com

After we decide if a product or service is medically necessary, we write a report about it. 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 **https://my.innovation-health.com**. Enter "Clinical Policy Bulletin" in the search bar. No Internet? Call us at the toll-free number on your digital member ID card. You can ask for a copy of any CPB named in a denial letter.

What to do if you disagree with us

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.

Call us to file a verbal complaint or to ask for the address to mail a written complaint. The phone number is on your digital member ID card. If you're not satisfied after talking to an Innovation Health representative, you can ask us to send your issue 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 statement that explains that your claim was denied. The letter also tells you what we need from you and how soon we will respond.

A "rush" review may be possible

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.

Get a review from someone outside Innovation Health

If the denial is based on a medical judgment, you may be able to get an outside review if you're not satisfied with your appeal (in most cases you will need to finish all of your internal appeals first). Follow the instructions on our response to your appeal.

Call us to ask for an external review form. You can also visit **https://my.innovation-health.com**. Enter "external review" into the search bar. An independent review organization (IRO) will assign your case to one of their experts. The expert will be a doctor or other professional who specializes in that area or type of appeal. You should have a decision within 45 calendar days of the request.

The outside reviewer's decision is final and binding; we will follow the outside reviewer's decision and you will not have to pay anything unless there was a filing fee.

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 **https://my.innovation-health.com** and enter "rights and resources" into the search bar to view the list. You can also call the number on your digital member ID card to request a printed copy or for more information.

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 — names 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 that 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. Advance 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 June 10, 2016.

Learn more about care management and quality management programs

We make sure your doctor provides quality care for you and your family. To learn more about these programs, log in to your secure member website at **https://my.innovation-health.com** and enter "commitment to quality" in the search bar. You can also call us to ask for a copy of the Commitment to Quality document. The toll-free number is on your digital 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 Innovation Health 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)

We obtain information from many different sources — particularly you, other insurers, health maintenance organizations or TPAs, and health care providers.

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 digital member ID card or visit us at **https://my.innovation-health.com**.

Anyone can get health care

We do not consider your race, disability, religion, sex, gender identity, 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."

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. This includes enrolling your spouse or children and other dependents. If that happens, you must apply within 60 days before you expect to lose coverage and 60 days after your coverage has ended.

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 60 days after certain life events if you chose not to enroll during the normal open enrollment period.

These life events include:

- Marriage
- Birth
- Adoption
- Placement for adoption

For more information or to request special enrollment, you can call the toll-free number on your digital member ID card. If you are not a member yet, you can call **1-888-443-1616**.

Innovation Health does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.

We are committed to Health Plan Accreditation by the National Committee for Quality Assurance (NCQA) as a means of demonstrating a commitment to continuous quality improvement and meeting customer expectations. You can find a complete list of health plans and their NCQA status on the NCQA website located at **www.ncqa.org**. Click on the "Report Cards" tab to search on "Health Plans."

To refine your search for other health care providers, click on "Clinicians" or "Other Healthcare Organizations." The link for "Clinicians" includes doctors recognized by NCQA in the areas of heart/stroke care, diabetes care, patient centered medical home and patient centered specialty practice. The recognition programs are built on evidence-based, nationally recognized clinical standards of care; therefore, NCQA provider recognition is subject to change. You can access the official NCQA directory of recognized clinicians at **http://recognition.ncqa.org**. The link for "Other Healthcare Organizations" includes "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 **1-888-443-1616**.
Si usted necesita este material en otro lenguaje, por favor llame al **1-888-443-1616**.

https://my.innovation-health.com

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Nondiscrimination Notice

Innovation Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Innovation Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Innovation Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Innovation Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator at:

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

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

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

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

TTY: 711

For language assistance in English call 855.425.8706 at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al 855.425.8706. (Spanish)

欲取得繁體中文語言協助，請撥打 855.425.8706，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le 855.425.8706 sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang 855.425.8706 nang walang bayad. (Tagalog)

T'áá shí shizaad k'ehjí bee shíká a'doowoł nínízingo Diné k'ehjí kojį' t'áá jíík'e hólne' 855.425.8706 (Navajo)

Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 855.425.8706 an. (German)

በ አሚርኛ የቋንቋ እገዛ ለማግኘት በ 855.425.8706 በነጻ ይደውሉ (Amharic)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 855.425.8706. (Arabic)

বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 855.425.8706-তে কল করুন। (Bengali-Bangala)

Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 855.425.8706 irratti bilisaan bilbilaa. (Cushite)

Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 855.425.8706. (Dutch)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 855.425.8706 gratis. (French Creole)

Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 855.425.8706 χωρίς χρέωση. (Greek)

(Gujarati) ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 855.425.8706 પર કૉલ કરો.

(Hindi) हिन्दी में भाषा सहायता के लिए, 855.425.8706 पर मुफ्त कॉल करें।

Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 855.425.8706. (Hmong)

Maka enyemaka asụsụ na Igbo kpọọ 855.425.8706 na akwụghị ụgwọ ọ bụla (Ibo)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 855.425.8706. (Italian)

日本語で援助をご希望の方は、855.425.8706まで無料でお電話ください。(Japanese)

လၢတ်မၤစၢၤတ်ကတိၤကျိဉ်အဂီၤ် ကျိဉ် ကိး 855.425.8706 လၢတအိဉ်ဒီးတ်လၢာ်ဘူဉ်လၢာ်စ့ၤဘဉ် (Karen)

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 855.425.8706번으로 전화해 주십시오. (Korean)

Ɓɛ́ m̀ ké gbo-kpá-kpá dyé pídyi ɖé Ɓǎsɔ́ɔ̀-wùɖù̀ǔn wɛ̃ɛ, ɖá 855.425.8706 (Kru-Bassa)

بۆ وەرگرتنی ڕێنوێنی پێوەندیدار بە زمان بە زمان بە ژمارەی 855.425.8706 بە خۆڕایی پەیوەندی بکەن. (Kurdish)

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 855.425.8706 ໂດຍບໍ່ເສຍຄ່າໂທ. (Laotian)

សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 855.425.8706 ដោយឥតគិតថ្លៃ។ (Mon-Khmer, Cambodian)

(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 855.425.8706 मा फोन गर्नुहोस् । (Nepali)

Fer Helfe in Deitsch, ruf: 855.425.8706 aa. Es Aaruf koschtet nix. (Pennsylvanian Dutch)

برای راهنمایی به زبان فارسی با شماره 855.425.8706 بدون هیچ هزینه ای تماس بگیرید. انگلیسی (Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 855.425.8706. (Polish)

Para obter assistência linguística em português ligue para o 855.425.8706 gratuitamente. (Portuguese)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 855.425.8706. (Russian)

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 855.425.8706. (Serbo-Croatian)

ܐܢ ܟܠܐ ܐܢܬ ܡܥܕܪܢܘܬܐ ܒܠܫܢܐ ܣܘܪܝܝܐ

ܐܚ ܠܝܗ ܐܡܢܐ ܕܒܠܫܐ 855.425.8706 ܡܓܢ. (Syriac-Assyrian)

భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 855.425.8706 కు కాల్ చేయండి. (తెలుగు) (Telugu)

สำหรับความช่วยเหลือทางด้านภาษาเป็นภาษาไทย โทร 855.425.8706 ฟรีไม่มีค่าใช้จ่าย (Thai)

Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 855.425.8706. (Ukrainian)

اُردو میں لسانی معاونت کے لیے 855.425.8706 پر مفت کال کریں۔ (Urdu)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 855.425.8706. (Vietnamese)

Fún ìrànlọ́wọ́ nípa èdè (Yorùbá) pe 855.425.8706 lái san owó kankan rárá. (Yoruba)