Important disclosure information

Health Maintenance Organization (HMO)

For small and large group health maintenance organization (HMO) plans from Banner Health and Aetna Health Plan Inc.

Banner|Aetna is the brand name for products and services provided by Banner Health and Aetna Health Insurance Company and Banner Health and Aetna Health Plan Inc. Health benefit and health insurance plans are offered and/or insured by Banner Health and Aetna Health Insurance Company and/or Banner Health and Aetna Health Plan Inc. (Banner|Aetna). Each insurer has sole financial responsibility for its own products. Banner Health and Aetna Health Insurance Company and Banner Health and Aetna Health Plan Inc. are affiliates of Banner Health and of Aetna Life Insurance Company and its affiliates (Aetna). Aetna and Banner Health provide certain management services to Banner|Aetna.

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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 **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 health maintenance organization (HMO)-based plan

If you're a member, not all of the information in this document applies to your specific HMO-based plan. Most information applies to all plans, but some does not. For example, not all plans have prescription drug benefits and some may limit certain services, like one eye exam per year.

For some plans, you must personally bear all costs if you use health care or purchase drugs not authorized by your plan. In addition, some plans are self-funded. This means your employer, and not Aetna, designed your plan. It may not cover services you want like certain plastic surgeries.

There's also information that may only apply to certain states. To be sure about which plan features apply to you, check your Summary of Benefits and Coverage plan documents. Can't find them? You can ask your benefits administrator or call Member Services to have a copy of your plan documents mailed to you.

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 **BannerAetna.com** and select "Find a Doctor" from the top menu bar to start your search.

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 **1-844-365-7374 (TTY: 711)**.

Choose a primary care physician (PCP)

Most HMO-based plans require you to select a PCP. You can change your PCP at any time. If it's an emergency, you don't have to call your PCP first.

Some cover your care at different levels, depending on whether you visit your chosen PCP, or if you go directly to any licensed doctor without seeing your PCP first. If you visit any licensed doctor without going to your PCP first, your out-of-pocket costs are often higher. Your PCP performs physical exams, order tests and screenings and will also refer you to a specialist when needed. 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 obstetrician-gynecologist (Ob/Gyn) as their PCP. An Ob/Gyn acting as a PCP will provide the same services and follow the same guidelines as any other PCP. See your plan documents for details.

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**.

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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 member ID card. The mailing address is:

Aetna
PO Box 14079
Lexington, KY 40512-4079

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 Arizona Appeals packet, included with this plan disclosure

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 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.

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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.

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 Arizona

Currently, Arizona does not have any state-specific pre-enrollment disclosure requirements.

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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 လၢတလိာ်လက်ဘူၣ်လက်စ့ၤ 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	ដើម្បីទទួលនេសវាផ្នែកភាសាដោយមិនគិតៃថ្លលពីអ្នកសូមទូរសព្ទទេលខ 1-888-982-3862 ។
Navajo	T’áá ni nizaad k’ehjí bee níká a’doowoł doo bą́ą́h 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	ܡܓܢ ܚܠܡܬ ܐܬܪܬܐ ܕܠܫܢܐ ܥܠ ܡܓܢܐܝܬ ܬܠܘܢ ܡܫܡܥܐ ܩܪܝ: ܡܢܝܢܐ ܒܗ، 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 .