Important disclosure information

For these small and large group plans:

- **Open Access Managed Plus**
- **Open Access HMO**
- **Open Access HMO Option**
- **PPO**

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Understanding your plan of benefits

Banner|Aetna health 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 certain plastic surgeries. 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.

Warning: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

Not all of the information in this booklet applies to your specific plan

Most of the information in this booklet applies to all plans, but some does not. For example, not all plans have deductibles or prescription drug benefits. Information about those topics will only apply if the plan includes those rules.

Where to find information about your specific plan

Your plan documents list all the details for the plan you choose. This includes what's covered, what's not covered and what you will pay for services. Plan document names vary.

They may include a Booklet-Certificate, Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Group Insurance Policy and/or any riders and updates that come with them.

If you can't find your plan documents, call Member Services to ask for a copy. Use the toll-free number on your member ID card.

Get plan information online and by phone

If you're already enrolled in a Banner|Aetna health plan

You have three convenient ways to get plan information anytime, day or night:

1. Log in to your member website

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 Banner|Aetna ID card handy to register. Then visit **banneraetna.com** and click "Log In." Follow the prompts to complete the one-time registration.

Then you can log in anytime to:

- Verify who's covered and what's covered
- Access your plan documents
- Track claims or view past copies of your Explanation of Benefits statements
- Use the online provider search tool to find network care
- Use our cost-of-care tools so you can know before you go
- Learn more about and access any wellness programs that come with your plan

2. Call Member Services at the toll-free number on your Banner|Aetna ID card

As a member you can use the Aetna Voice Advantage® self-service options to:

- Verify who's covered under your plan
- Find out what's covered under your plan
- Get an address to mail your claim and check a claim status
- Find other ways to contact us
- Order a replacement member ID card
- Be transferred to behavioral health services (if included in your plan)

Banner|Aetna is the brand name used for products and services provided by Banner Health and Aetna Health Insurance Company and Banner Health and Aetna Health Plan Inc. Health benefits and health insurance plans are offered, underwritten and/or administered 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|Aetna is an affiliate 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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You can also speak with a representative to:

- Understand how your plan works or what you will pay
- Get information about how to file a claim
- Get a referral
- Find care outside your area
- File a complaint or appeal
- Get copies of your plan documents
- Connect to behavioral health services (if included in your plan)
- Find specific health information
- Learn more about our Quality Management program

Not yet a member?

For help understanding how a particular medical plan works, you should review your Summary of Benefits and Coverage document or contact your employer or benefits administrator.

Search our network for doctors, hospitals and other health care providers

Use our 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.

Just visit **banneraetna.com** and select "Find a doctor". You'll need to select the plan you're interested in from the drop-down box.

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

Help for those who speak another language and for those who are deaf
If you require language assistance, please call the Member Services number on your 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 de Servicios al Miembro que figura en su tarjeta de identificación de Banner|Aetna, y un representante de 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 de que está llamando.

Get a FREE printed directory

To get a free printed list of doctors and hospitals, call the toll-free number on your ID card. If you're not yet a member, call **1-800-381-6789.**

Costs and rules for using your plan

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, 20 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 20 percent would be $20. 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 $1,000, you have to pay the first $1,000 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:

- **Inpatient hospital deductible** – Applies when you are a patient in a hospital
- **Emergency room deductible** – The amount you pay when you go to the emergency room - this is waived if you are admitted to the hospital within 24 hours

Note: These are separate from your general deductible. For example, your plan may have a $1,000 general deductible and a $250 emergency room deductible. This means you pay the first $1,000 before the plan pays anything. Once the plan starts to pay, if you go to the emergency room you will pay the first $250 of that bill.

Your costs when you go outside the network

Network-only plans

Health Network Only plans are network-only plans. That means the plan covers health care services only when provided by a doctor who participates in the network. Not every hospital, health care facility, physician or other types of providers participate in the network. If you receive services from an out-of-network doctor or other health care provider, you will have to pay all of the costs for the services. See "Emergency and urgent care and care after office hours" for more information.

Plans that cover out-of-network services

With the Open Choice, Health Network Option and Open Access Managed Choice plans, you may choose a doctor in our network. You may choose to visit an out-of-network doctor. We cover the cost of care based on if the provider, such as a doctor or hospital, is in network or out of network. We want to help you understand how much we will pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this care. The following are examples for when you see a doctor:

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

Out of network means we do not have a contract for discounted rates with that doctor. We don't know exactly what an out-of-network doctor will charge you. If you choose a doctor who is out of network, your Banner|Aetna 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 doctor.

Going in network just makes sense

- We have negotiated discounted rates for you.
- 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 national network.

To learn more about how we pay out-of-network benefits, visit **banneraetna.com**. Type "how Banner|Aetna pays" in the search box.

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

When you choose to see an out-of-network doctor, 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 Member Services at the toll-free number on your member ID card to find out the method your plan uses to reimburse out-of-network doctors. You can also ask for an estimate of your share of the cost for out-of-network services you are planning. The way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. See "Emergency and urgent care" to learn more.

You never need referrals with open access plans

As an Open Access or PPO plan member, you never need a referral from your regular doctor to see a specialist. You also do not need to select a primary care provider (PCP), but we encourage you to do so to help you navigate the health care system.

Precertification: Getting approvals for services

Sometimes we will pay for care only if we have given an approval before you get it. 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 Banner|Aetna network, your doctor gets precertification from us. But if you get your care outside our network, you must call us for precertification when that's required.

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 on your member ID card to begin the process. To make sure you're covered, you must get the precertification before you receive the care - unless it's an emergency. You do not have to get precertification for emergency services.

Notice: You must personally bear all costs if you use health care not authorized by this plan or purchase drugs that are not authorized by this plan.

What we look for when reviewing a 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 the place requested to perform the service are cost effective. 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 case management programs. If so, one of our nurses may contact you.

Precertification does not 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.

Avoid unexpected bills

Check your plan documents to see what's covered before you get health care. Can't find your plan documents? Call Member Services to ask a specific question or have a copy mailed to you.

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.

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 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.

You are covered for emergency care
You have emergency coverage while you are traveling or if you are near your home. That includes students who are away at school.

Sometimes you don't have a choice about where you go for care, like if you go to the emergency room for a heart attack or a car accident. When you need care right away, go to any doctor, walk-in clinic, urgent care center or emergency room. When you have no choice, we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance and deductibles for your network level of benefits.

We'll review the information when the claim comes in. If we think the situation was not urgent, we might ask you for more information and may send you a form to fill out. Please complete the form, or call Member Services to give us the information over the phone.

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 to **banneraetna.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

Check your plan documents to see if your plan includes prescription drug benefits.

Some plans encourage generic drugs over brand-name drugs
A generic drug is the same as a brand-name drug in dose, use and form. They are FDA-approved and safe to use. Generic drugs usually sell for less, so many plans give you incentives to use generics. 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 pharmacy drug guide (formulary). This guide shows which prescription drugs are covered on a preferred basis. It also explains how we choose medications to be in the guide.

When you get a drug that is not on the preferred drug guide, your share of the cost will usually be more. Check your plan documents to see how much you will pay. You can use those drugs if your plan has an open formulary, but you'll pay the highest copay under the plan. If your plan has a closed formulary, those drugs are not covered.

We may receive rebates

Banner|Aetna, or its affiliate(s), may receive rebates from drug manufacturers that may be taken into account in determining our pharmacy drug guide. Rebates may reduce the amount a member pays the pharmacy for covered prescriptions. This amount would be applied after the coinsurance is calculated. Information is subject to change.

Sometimes, in plans where you pay a percentage of the cost instead of a flat dollar amount, you may pay more for a drug in the preferred drug guide than for a drug not in the guide.

Home delivery and specialty drug services are included in your plan

Home delivery pharmacies are included in your network. They provide convenient options for filling medicines that are taken every day and specialty medicines that treat complex conditions.

You might not have to stick to the preferred drug guide

Sometimes your doctor might recommend a drug that's not in our pharmacy drug guide. 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. 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, someone helping you or your doctor can ask for a medical 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 also may not cover drugs that we haven't reviewed yet. You, someone helping you or your doctor may need to get our approval (a medical exception) to use one of these drugs.

Get a copy of the preferred drug guide

You can find the pharmacy drug guide (formulary) on our website at **www.banneraetna.com/en/pharmacy-resources**. You can call the toll-free number on your member ID card to ask for a printed copy. We frequently add new drugs to the guide. Look online or call Member Services for the latest updates.

Have questions? Get answers.

Ask your doctor about specific medications. Call the number on your member ID card to ask about how your plan pays for them. Your plan documents also spell out what's covered and what is not.

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 behavioral health number on your member ID card.
- Call Member Services if no other number is listed.
- Employee assistance program (EAP) professionals can also help you find a mental health specialist.

Get information about using network therapists

We want you to feel good about using the Banner|Aetna network for mental health services. You can visit **banneraetna.com** and select Find A Doctor to learn about these services.No Internet? Call Member Services instead. Use the toll-free number on your member ID card to ask for a printed copy.

Mental health screening, support, and prevention programs

We offer the following programs for our members:

- **Maternity Program:** Offers behavioral health screening and support through perinatal and postpartum depression education, screening and treatment referral
- **Behavioral Health program:** Offers screening and prevention programs through the Opioid Overdose Risk Screening (OORS) Program

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.

Important benefits for women

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (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 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. 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

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**.

Knowing what is covered

Here are some of the ways we determine what is covered:

We check to see if it's medically necessary

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 to see if you have one. It might also be to treat an injury or illness.

For the product or service to be medically necessary, it:

- 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. It will explain why it was denied, and how you can appeal the denial. You have the same right to appeal if a physician's group denied coverage. You can call Member Services to ask for a free copy of the materials we use to make coverage decisions. Or visit **banneraetna.com** to read our policies. Doctors can write or call our Patient Management department with questions. Contact Member Services 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 – including 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 banneraetna.com

We write a report about a product or service after we decide if it is medically necessary. 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 **banneraetna.com**. You can find them under "Providers." No Internet? Call Member Services at the toll-free number on your member ID card. Ask for a copy of a CPB for any product or service.

What to do if you disagree with us

Arizona complaints, appeals and external review

Call Member Services to file a verbal complaint or to ask for the address to mail a written complaint. The phone number is on your member ID card. You can also email Member Services through the member website.

If you're not satisfied after talking to a Member Services 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

See the Arizona Appeals packet, which accompanies this plan disclosure, for more information about appealing an adverse benefit determination.

If you have questions, just contact member services at phone number on your member ID card.

Get a review from someone outside Banner|Aetna

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 Member Services to ask for an external review form. You can also visit **banneraetna.com**. Enter "external review" into the search bar.

A rush review may be possible

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

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 Visit **https://www.banneraetna.com/en/legal-notices/rights-resources/member-rights-and-responsibilities.html** to view the list. You can also call Member Services at the number on your member ID card to ask for a printed copy.

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[1]:

- Durable power of attorney – name 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 don't want 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.

Learn about our quality management programs

We make sure your doctor provides quality care for you and your family. To learn more about these programs, including goals and outcomes, go to **banneraetna.com**. Enter "Quality Management and Improvement Efforts" in the search bar. You can also call Member Services to ask for a printed copy. The toll-free number is on your 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 Banner|Aetna Privacy Policy
When necessary for your care or treatment, or 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) (this includes plan sponsors and/or employers)

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

[1]Source: American Academy of Family Physicians. Advance Directives and Do Not Resuscitate Orders. January 2012. Available at **https://familydoctor.org/advance-directives-and-do-not-resuscitate-orders/**. Accessed May 15, 2018.

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 member ID card or visit us at **banneraetna.com**.

Anyone can get health care

We do not consider your race, disability, religion, sex, 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 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? A new dependent changes everything. And you can change your mind. You can enroll within 31 days after a life event if you chose not to enroll during the normal open enrollment period. Life events include:

- Marriage
- Birth
- Adoption
- Placement for adoption

Talk to your benefits administrator for more information or to request special enrollment.

Nondiscrimination for genetic testing

We will not in any way use the results of genetic testing to discriminate against applicants or enrollees.

We are committed to Accreditation by the National Committee for Quality Assurance (NCQA) as a means of demonstrating a commitment to continuous quality improvement and meeting customer expectations. A complete list of health plans and their NCQA status can be found on the NCQA website located at **http://reportcard.ncqa.org**.

To refine your search, we suggest you search these areas:

1. **Health Plans** – for HMO and PPO health plans
2. **Health Care Providers** – for physicians recognized by NCQA in the areas of Physician Practice Connections, Physician Practice Connections-Patient Centered Medical Home, Patient Centered Medical Home, Heart/Stroke, Diabetes, and Patient Center Specialty Practice. Providers, in all settings, achieve recognition by submitting data that demonstrate they are providing quality care. The program constantly assesses key measures that were carefully defined and tested for their relationship to improved care; therefore, NCQA provider recognition is subject to change.
3. **Other Health Care Organizations** –
   - **Filter your search by "Managed Behavioral Healthcare Organizations"** - for behavior health accreditation
   - **Filter your search by "Credentials"** - for credentialing certification

If you need this material translated into another language, please call Member Services at 1-800-381-6789.

Si usted necesita este material en otro lenguaje, por favor llame a Servicios al Miembro al 1-800-381-6789.

Banner|Aetna 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 **1-800-381-6789**.

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 (CA HMO customers: P.O. Box 24030 Fresno, CA 93779), **1-800-648-7817, TTY: 711**,

Fax: **859-425-3379** (CA HMO customers: **860-262-7705**), **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 1-800-381-6789 .

Para acceder a los servicios de idiomas sin costo, llame al 1-800-381-6789 . (Spanish)

如欲使用免費語言服務，請致電 1-800-381-6789。(Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 1-800-381-6789 . (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-800-381-6789 . (Tagalog)

T'áá ni nizaad k'ehjí bee níká a'doowoł doo bą́ą́h ílínígóó kojį' hólne' 1-800-381-6789 . (Navajo)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-800-381-6789 an. (German)

የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-800-381-6789 ይደውሉ። (Amharic)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-800-381-6789 . (Arabic)

আপনাকে বিনামূল্যে ভাষা পরিষেবা পেতে হলে এই নম্বরে টেলিফোন করুন: 1-800-381-6789 । (Bengali)

आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, 1-800-381-6789 पर कॉल करें। (Hindi)

Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-800-381-6789 . (Ibo)

무료 언어 서비스를 이용하려면 1-800-381-6789 번으로 전화해 주십시오. (Korean)

M̀ dyi wuɖu-dù kà kò ɖò ɓě dyi mɔ́uń nì Pídyi ní, nìí, ɖá nɔ̀ɓà nìà kɛ:1-800-381-6789. (Kru-Bassa)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-800-381-6789 تماس بگیرید. (Persian-Farsi)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-800-381-6789 . (Russian)

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-800-381-6789 . پر بات کریں۔ (Urdu)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-800-381-6789 . (Vietnamese)

Lati wọnú awọn isẹ èdè l'ọfẹ fun ọ, pe 1-800-381-6789 . (Yoruba)

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