

Important disclosure information about Utah HMO-based plans:

- Aetna® HMO
- Aetna Health Network OnlySM
- Aetna Health Network OptionSM
- Aetna SelectSM
- Quality Point-of-Service® (QPOS®)

Health benefits and health insurance plans are provided by Aetna Health of Utah Inc.

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

We offer quality health plans

By following health plan accreditation standards of the National Committee for Quality Assurance (NCQA), we offer you quality health plans. Visit [Aetna.com/individuals-families-health-insurance/document-library/documents/2019Disclosures/NCQA-MED-Disclosures-FI-SI.pdf](https://www.aetna.com/individuals-families-health-insurance/document-library/documents/2019Disclosures/NCQA-MED-Disclosures-FI-SI.pdf) to learn more about how we meet the NCQA accreditation and standards. You can also call us at the number on your member ID card to ask for a printed copy.

This document details how to:

Understand your health plan

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

Get plan information online and by phone

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

Know the costs and rules for using your plan

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

Understand your rights and responsibilities

- Member rights and responsibilities
- Notice of Privacy Practices

Features of a 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.

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 [Aetna.com](https://www.aetna.com) and, to start your search, select "Find Care" from the top menu. To learn more about how we pay out-of-network benefits when a plan allows them, visit [Aetna.com](https://www.aetna.com) and type "how Aetna pays" into the search box.

Get a free printed directory

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



Choose a primary care physician (PCP)

Most 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 U.S. trade sanctions

If U.S. trade sanctions consider you a "blocked person," the plan can't provide benefits or coverage to you. If you travel to a country sanctioned by the United States, the plan, in most cases, can't provide benefits or coverage to you. Also, if your health care provider is a blocked person or is in a sanctioned country, we can't pay for services from that provider. For example, if you receive care while traveling in another country and the health care provider is a blocked person or is in a sanctioned country, the plan can't pay for those services. For more information, visit [Treasury.gov/resource-center/sanctions/pages/default.aspx](https://www.treasury.gov/resource-center/sanctions/pages/default.aspx) to read about U.S. trade sanctions.

Coverage for transplants and other complex conditions

Our National Medical Excellence Program® (NME) is for members who need a transplant or have a condition that can only be treated at a certain hospital. You may need to visit an Aetna Institutes of Excellence™ hospital to get coverage for the treatment. Some plans won't cover the service if you don't. We choose hospitals for the NME program based on their expertise and experience with these services. We also follow any state rules when choosing these hospitals.

What does “medically necessary” mean?

It means your doctor ordered a product or service for an important medical reason. It might be to help prevent a disease or condition, or to check to see if you have one. It might also be to treat an injury or illness. The product or service must be ordered by your doctor and:

- Must meet a normal standard for doctors
- Must be the right type, in the right amount, for the right length of time and for the right body part
- Must be known to help the symptom
- Can't be just for the member's or the doctor's convenience
- Can't cost more than another service or product that is just as effective

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

Clinical policy bulletins

We write a report about a product or service when we decide if it's medically necessary. We call the report a clinical policy bulletin (CPB). CPBs guide us in deciding whether to approve a coverage request. Your plan may not cover everything our CPBs say is medically necessary. Each plan is different, so check your plan documents. CPBs are not meant to advise you or your doctor on your care. Only your doctor can give you advice and treatment. Talk to your doctor about any CPB related to your coverage or condition.

You and your doctor can visit [Aetna.com/health-care-professionals/clinical-policy-bulletins.html](https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html) to read CPBs. No internet? Call the number on your Aetna member ID card and ask for a copy of a CPB for any product or service.

What to do if you disagree with us

If you disagree with something we've done, you can talk to us on the phone. Or you can mail us a written complaint. The phone number is on your Aetna member ID card. You can also email us at [Aetna.com](mailto:complaints@etna.com).

Still not satisfied?

You can file an appeal

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

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

The letter we sent you tells you:

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

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

For help or to learn more:

- Visit your state's government website at [USA.gov/state-tribal-governments](https://www.usa.gov/state-tribal-governments)
- Call the phone number on your member ID card

You can contact an independent review organization (IRO)

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

You can get a rush review

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

Member rights and responsibilities

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

Nondiscrimination policy for genetic testing

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

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

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

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

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

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

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

Benefits will be provided to a person who has already undergone a mastectomy as a result of breast cancer while covered under a different health plan. Coverage is provided according to your plan design and is subject to plan limitations, copays, deductibles, coinsurance and referral requirements, if any, as outlined in your plan documents.

For more information:

- Call the number on your member ID card
- Visit the U.S. Department of Labor at [DOL.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/your-rights-after-a-mastectomy.pdf](https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/your-rights-after-a-mastectomy.pdf)

Your right to enroll later

You might choose not to enroll now because you already have health insurance. You may be able to enroll later if you lose that other coverage or if your employer stops contributing to the cost. This includes enrolling your spouse or children and other dependents. If that happens, you must apply within 31 days after your coverage ends (or after the employer stops contributing to the other coverage).

When you have a new dependent

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

Important information for Utah plans

Utah notice of access to health care providers in rural counties

You may be entitled to coverage for health care services from noncontracted providers if you live or reside within 30 paved road miles of the providers, or if you live or reside in closer proximity to the providers than to your contracted providers.

At this time, Aetna is contracted with all of the rural independent hospitals and federally qualified health centers. Please refer to your online provider directory for the most current information.

The status of contracted providers may change periodically, so please check our website or call for verification. Please be advised that if you choose a noncontracted provider, you will be responsible for any charges not covered by your health insurance plan.

If you have questions concerning your rights to see a noncontracted provider, you may contact your managed care organization at **1-888-646-2496 (TTY: 711)**. If the managed care organization does not resolve your problem, you may contact the Office of Consumer Health Assistance in the Utah Insurance Department, toll-free.

How to get the most up-to-date lists

The contracted independent hospitals and federally qualified health centers lists may change periodically. To get the most up-to-date information, please visit your member website on **Aetna.com** or call us at the toll-free phone number on your Aetna® member ID card.

Important note: If you choose a noncontracted provider, you will be responsible for any charges not covered by your health insurance plan.

Questions about your rights?

If you have questions about your rights to see a provider on the list on this page or the prior page, you may contact us toll-free at **1-866-646-2496 (TTY: 711)**.

If we do not resolve your problem, you may contact:

The Utah Insurance Department, Office of Consumer Health Assistance

- Toll-free phone: **1-800-439-3805**
- Direct phone: **801-538-3077**
- Email: **Health.UID@Utah.gov**

Choosing a qualified obstetrician-gynecologist as your primary care provider in Utah

If your plan requires you to select a primary care provider to receive optimum coverage, you may select an obstetrician-gynecologist — as long as she or he is also currently qualified as a primary care provider — to be your primary care provider.

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 the number on your ID card.

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: PO Box 24030 Fresno, CA 93779), **1-800-648-7817, TTY: 711, Fax: 859-425-3379** (CA HMO customers: **860-262-7705**).

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)**.

TTY: 711

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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