Important disclosure information about Missouri traditional and PPO-based plans:

Aetna Choice® POS II

Aetna Open Access® Elect Choice® EPO

Open Access Aetna Select℠

Open Choice® PPO

Traditional Choice® Indemnity

Health insurance plans are offered, underwritten and/or administered by Aetna Life Insurance Company (Aetna).

Table of contents

00.28.360.1-MO (6/20)

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

We offer quality health plans

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

This document details how to:

Understand your health plan

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

Get plan information online and by phone

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

Know the costs and rules for using your plan

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

Understand your rights and responsibilities

- Member rights and responsibilities
- Notice of Privacy Practices

Features of a traditional or preferred provider organization (PPO)-based plan

If you're a member, not all of the information in this document applies to your specific traditional or PPO-based plan. Most information applies to all plans, but some does not. For example, not all plans have prescription drug or behavioral health benefits. There's also information that may only apply to a handful of states and plans. To be sure about which plan features apply to you, check your Summary of Benefits and Coverage plan documents. Can't find them? Ask your benefits administrator or call Member Services to have a copy of your plan documents mailed to you.

How some plans pay

Providers set the rates to charge you. It may be higher (sometimes, much higher) than what your Aetna® plan allows. For some plans, your doctor may bill you for the dollar amount that the plan doesn't allow and no dollar amount above the allowed charge will count toward your deductible or out-of-pocket limits. This means you're fully responsible for paying everything above the amount the plan allows for a service or procedure. However, emergency care is always covered by your plan, and you don't have to get prior approval.

Plans pay for your health care depending on the plan that you, or your employer, chooses. Some plans pay for services by looking at what Medicare would pay and adjusting that amount up or down. Plans range from paying 90% of Medicare (that is 10% less than Medicare would pay) up to 300% of Medicare (the Medicare rate multiplied by three). Some plans pay for services based on what is called the "usual and customary" charge. These plans use information from FAIR Health, Inc., a not-for-profit company that reports how much providers charge for services in any ZIP code. You can call Member Services at the number on your member ID card to find out the method your plan uses to pay providers.

Not yet a member?

For help understanding how a certain medical plan works, review the plan's Summary of Benefits and Coverage document.

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Avoid unexpected bills

To avoid a surprise bill, make sure you check your plan documents to see what's covered before you get health care. Also, make sure you get care from a provider who is part of your plan's network. This just makes sense because:

- We have negotiated lower rates for you
- Network doctors and hospitals won't bill you above our negotiated rates for covered services
- You have access to quality care from our national network

To find a network provider, sign in to **Aetna.com** and select "Find Care" from the top menu bar to start your search. To learn more about how we pay out-of-network benefits when a plan allows them, visit **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 traditional or PPO-based plans don't require you to select a PCP. However, some employers may require you to do so. We strongly encourage you to choose one because your PCP can help coordinate your care and order tests and screenings. If it's an emergency, you don't have to call your PCP first. You may change your PCP at any time.

Women who are members may choose an Ob/Gyn as their PCP. Ob/Gyns acting as your PCP will provide the same services and follow the same guidelines as any other PCP. You may also be able to choose a pediatrician for your child(ren)'s PCP. See your plan documents for details.

Getting approval for some services

Usually, we will pay for care only if we have given an approval before you get it. Your plan documents list all the services that require you to get prior approval.

First, we check to see that you're still a member. And we make sure the service is medically necessary for your condition. We also make sure the service and place requested to perform the service are cost effective. Our decisions are based solely on the existence of coverage and the appropriateness of care and service, using nationally recognized guidelines. We may suggest a different treatment or place of service that is just as effective but costs less. We also look to see if you qualify for one of our care management programs. If so, one of our nurses may contact you. Precertification doesn't verify whether you have reached any plan dollar limits or visit maximums for the service requested. So, even if you get approval, the service may not be covered.

No coverage, based on U.S. trade sanctions

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

Coverage for transplants and other complex conditions

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

What does "medically necessary" mean?

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

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

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

Clinical policy bulletins

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

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

What to do if you disagree with us

If you disagree with something we've done, you can talk to us on the phone. Or you can mail us a written complaint. The phone number is on your Aetna member ID card. You can also email us at **Aetna.com**.

Still not satisfied?

You can file an appeal

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

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

The letter we sent you tells you:

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

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

For help or to learn more:

- Visit your state's government website at **USA.gov/state-tribal-governments**
- Call the phone number on your member ID card

You can contact an independent review organization (IRO)

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

You can get a rush review

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

Member rights and responsibilities

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

Nondiscrimination policy for genetic testing

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

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

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

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

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

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

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

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

For more information:

- Call the number on your member ID card
- Visit the U.S. Department of Labor at **DOL.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/your-rights-after-a-mastectomy.pdf**

Your right to enroll later

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

When you have a new dependent

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

Important information for Missouri plans

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

Use our online search tool at **Aetna.com** 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.

Not every participating health care provider will be accepting new patients. We identified providers who were not accepting patients at the time of their initial listing in the physician directory and online search tool; however, the status of a provider's practice may have changed.

For the most current information, you may contact the provider directly or call us at the number listed on your ID card. **Note:** In the state of Missouri, women who are members may not choose an obstetrician gynecologist (Ob/Gyn) as their PCP.

Precertification and utilization review information

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 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 contain information on 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.

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. Call the number on your 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.

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."

Preservice request

A preservice request for authorization involves services you have not yet received and which require precertification. We will make a decision within 36 hours, which includes one working day, of obtaining all necessary information. We will provide verbal or electronic notice to the provider within 24 hours for approval or an adverse decision.

Initial determinations — For inpatient hospitalizations and ongoing courses of treatment, we will make our initial determination within 36 hours of receiving a completed request. We will then notify your provider of the decision within 24 hours of making the decision. We will also send written or electronic confirmation of the decision to you (or your designated representative) and your provider within 24 hours of the verbal notification. If the service is certified, we will notify your health care provider by telephone within 24 hours. We will provide written or electronic confirmation to you or your designated representative and your doctor within two working days of the telephone notice.

If there is an adverse determination (such as a denial or reduction of benefit), we will notify your doctor by telephone within 24 hours. Written/electronic confirmation will follow within one working day of the telephone notice.

Concurrent review — We will review your case while you are confined on an inpatient basis to make sure you received the appropriate level of care.

We must make our determination within one working day of obtaining all necessary information. If the service is certified, we will notify your doctor by telephone within one working day. We will send written/electronic confirmation to you or your designated representative and your doctor within one working day of our telephone notice.

If there is an adverse determination (such as a denial or reduction of benefits), we will notify your doctor by telephone within 24 hours and follow that up with written notice within one working day of our phone call. Your services will continue without liability to you until you have been notified.

Discharge planning — This can be initiated at any stage of the patient management process and begins when we receive your postdischarge needs during precertification or concurrent review. Your discharge plan may include a variety of services or benefits after you leave the facility.

Retrospective record review — This review is conducted after you have received services. The purpose is to retrospectively analyze potential quality and utilization issues, initiate appropriate follow-up action based on quality or utilization issues and review all appeals of inpatient concurrent review decisions for coverage of health care services. Our effort to manage the services provided to you includes the retrospective review of claims submitted for payment and of medical records. We will make retrospective review determinations within 30 working days of obtaining all necessary information. Notice of the determination will be provided to you in writing within 10 days of the determination. For cases in which you or your provider will not release the necessary information, we may deny the services.

Reconsideration — For initial and concurrent review of services, we will give your doctor an opportunity to request, on your behalf, a reconsideration of an adverse determination by the individual making the determination. Reconsideration will occur within one working day of receipt of the request. It is conducted between the doctor and reviewer, or a clinical peer designated by the reviewer if the reviewer is not available. If this reconsideration does not resolve the issue, you, your designated representative or your provider on your behalf may appeal the adverse determination.

Reconsideration is not a prerequisite to an appeal.

How you or your doctor may contact us:

- Call the number on your ID card to request precertification.
- We prefer electronic submission for precertification requests and inquiries. Your doctor may call **1-800-624-0756** to confirm benefits and eligibility.
- For information about Clinical Policy Bulletins or our online provider search tool, please see your plan documents or refer to those topics in this disclosure document.
- Contact **1-855-240-0535** to precertify oral medications only.
- Contact **1-866-782-2779** for information on injectable medications.

Precertification approvals are valid for six months.

Your costs when you go outside the network

If you go to a provider or hospital that is out of your plan's network, you usually pay more. A plan with network coverage only means the plan covers *only* the costs of health care services provided by a doctor who participates in the network. If you receive services from an out-of-network doctor or other health care provider, you will have to pay all the costs for the services. We do offer plans that cover some of the costs for out-of-network services, but you'll still pay less if you go to a doctor in our network.

Out-of-network emergency services are covered as if you got care in network. When you receive covered services from certain out-of-network providers at an in-network facility or while receiving emergency services at an out-of-network facility, the most you can be billed is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balanced billed for any other amount. For plans with no out-of-network benefits, two mental health visits with an out-of-network provider are covered.

Additional information on complaints, appeals and external review

You have the right to designate a representative to help you with the complaint, appeal or external review process.

Contact Member Services to file a verbal complaint or to ask for the address to mail a written grievance

Please tell us if you are not satisfied or disagree with a response you received from us or with how we do business. You have the right to file a formal complaint (grievance) when a dispute is about referrals or covered benefits.

You can:

- Log in at **Aetna.com** to email Member Services through the member website
- Use the phone number on your ID card
- Call **1-877-872-3862 (TTY: 711)** to be connected to the appropriate unit

If you're not satisfied after talking to us, you can ask us to send your issue to the appropriate complaint department.

When sending a written grievance, you will need to include a detailed description of the matter and include copies of any records or documents you think are relevant to the matter. We will acknowledge the complaint within ten working days of receipt of your complaint. All disputes involving clinical decisions will be made by qualified clinical personnel.

If we deny a claim, our reason for the denial will be explained in our response letter. To file an appeal, follow the directions in the letter or Explanation of Benefits (EOB) statement that says your claim was denied. We will make a determination on the grievance within the time frames listed in the chart below.

Second-level review
You are entitled to a second-level review by a committee if we uphold the denial at the first level of appeal. We will make a determination on the grievance within the time frames listed in the chart below.

A "rush" review of an appeal may be possible
If your doctor thinks you cannot wait for an answer, you can ask for an expedited review. If we agree to the urgency, we'll make our decision within 36 hours. You can do this for Level 1 or Level 2 appeals.

Get a review from someone outside Aetna
You may be able to get an outside review if you're not satisfied with your appeal if:

- The requested health care service (admission, availability of care, continued stay or other health care service) does not meet the health plan's requirements for medical necessity, appropriateness of care, health care settings, level of care or effectiveness of a covered benefit
- The requested health care service has been found to be experimental or investigational
- You did not receive a timely decision from us
- Your coverage was rescinded

Follow the instructions on our response to your appeal. Call us to ask for an external review form. You can also visit **Aetna.com**. Enter "external review" into the search bar.

An independent review organization (IRO) will assign your case to an outside expert. The expert will be a doctor or other professional who specializes in the relevant area or type of appeal. You should have a decision within 30 calendar days of the request. The outside reviewer's decision is final and binding; we will follow the outside reviewer's decision. We will also pay the cost of the review.

Aetna time frame for responding to a grievance

Type of notice	Urgent care claim	Preservice claim	Postservice claim	Concurrent care claim
Grievance Level 1 and Level 2	36 hours We will confirm our decision in writing within 3 working days of the initial decision	15 calendar days or 5 days after our investigation is complete (whichever is earlier)	20 working days* or 5 days after our investigation is complete (whichever is earlier)	As appropriate to type of claim
Extensions	None	None	30 calendar days	

*If we cannot make a decision within the time frame listed, we will inform the member and give clear, specific reasons. We will, however, make a decision within 30 calendar days thereafter.

Missouri Department of Commerce and Insurance (DCI)

You have the right to contact the director's office at any time for help with any inquiry, grievance or appeal at:

Missouri Department of Commerce and Insurance

Office of the Director
301 West High Street, Room 530
PO Box 690
Jefferson City, Missouri 65101

Phone: **1-800-726-7390**

This state regulatory agency can help you understand your rights.

Visit **http://insurance.mo.gov/** for more information about your rights in Missouri.

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)

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

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

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

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

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

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

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

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

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

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

00.28.360.1-MO (6/20)