Important disclosure information about traditional and PPO-based plans:

Aetna Choice® POS II
Aetna Health Network Only℠
Aetna Health Network Option℠
Aetna Open Access® Elect Choice® EPO
Aetna Open Access® Managed Choice®
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).

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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** 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 non-English speakers and for people who are deaf or hard of hearing.
- 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

f 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.

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® 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 National Medical Excellence 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 go to **Aetna.com** to email us.

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.

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Important information for certain states and plans

Here is additional disclosure content that varies by state.

Colorado

Network access plan

Aetna® keeps network access plans for its provider networks in Colorado. The plans describe how we monitor the networks to be sure they meet our members' health care needs. To get a copy of the plans, contact us at the number on your member ID card. Or download them:

- Go to **Aetna.com**
- Scroll to the bottom of the page and select "Plan disclosures"
- Select "State-Specific Information"
- Scroll down to find "Colorado"

Notice for the Patient Protection and Affordable Care Act-compliant small employer policies

This policy provides dental benefits to individuals up through age 18 only. This policy is offered so the purchaser will have pediatric dental coverage, as required by the act. If you are age 19 or older, you need to pay the full price for any dental care you receive with this plan. However, you can buy a separate plan that includes adult dental care benefits, so you'll be covered.

Delaware

Scalp hair prosthesis benefit

Aetna plans cover the cost of a scalp hair prosthesis worn for hair loss suffered as a result of alopecia areata resulting from an autoimmune disease. The same limitations and guidelines that apply to other prostheses as outlined in your plan documents apply, but this benefit is limited to $500 per year.

Florida

Direct access to a network chiropractor and podiatrist

You have direct access to a participating primary care chiropractic and podiatric provider of your choice and do not need a referral from your PCP to access the benefits covered under your health benefits plan.

Direct access to a network dermatologist

You have direct access to a participating primary care dermatologist provider of your choice and do not need a referral from your PCP to access the benefits covered under your health benefits plan.

Georgia

Get a free printed directory

If you live in Georgia, you can call toll-free at **1-800-223-6857 (TTY: 711)** to confirm that the preferred provider in question is in the network and is accepting new patients.

Georgia clarifies the prudent layperson standard.

It now includes **mental** or physical conditions in need of emergency care.

Explanation of what constitutes an emergency situation and emergency services

Emergency situation

Any physical or mental condition of a recent onset and severity. Regardless of your diagnoses, the symptoms would be severe enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness or injury is of such a nature that failure to obtain immediate medical care could result in:

1. placing the patient's health in serious jeopardy.
2. serious impairment to bodily functions or
3. serious dysfunction of any bodily organ or part.

Emergency services

Physical or mental health care services, including stabilization, rendered after the recent onset of a medical or traumatic condition, sickness or injury exhibiting severe symptoms. This includes a mental health condition or substance use disorder. Regardless of your diagnoses, the symptoms would be severe enough to lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness or injury is of such a nature that failure to obtain immediate medical care could result in:

1. placing the patient's health in serious jeopardy.
2. serious impairment to bodily functions or
3. serious dysfunction of any bodily organ or part.

Direct access to network an obstetrician-gynecologist (Ob/Gyn)

Women who are members have direct access to the participating primary Ob/Gyn provider of their choice and don't need a referral from their PCP for:

- A routine well-woman exam (including a Pap smear, when appropriate)
- An unlimited number of visits for gynecological problems
- An unlimited number of visits for follow-up care

Direct access to a network dermatologist

You have direct access to the participating dermatologist provider of your choice and do not need a referral from your primary care physician to access dermatologic benefits covered under your health plan.

How to nominate an out-of-network doctor for network benefits

If you prefer to receive care from a doctor who isn't in the network, just call Member Services at the number on your member ID card (you'll get that card after you enroll). You can nominate a specific doctor to serve as a network doctor for you and your covered family members.

The doctor must agree to accept the plan's compensation rates. The doctor must also adhere to the plan's policies and quality assurance requirements. And the doctor must meet all other reasonable criteria, just like all the doctors in our network. If the doctor agrees, you will pay the same network cost sharing for that doctor's services as you pay for other network doctors.

We will adjust your premium to add the doctor to the network. The amount will depend on whether you have single or family coverage. Member Services representatives can tell you how much extra you'll pay. Talk to your employer or benefits administrator to find out exact pricing and other information.

A summary of any agreement or contract between Aetna and any health care provider will be made available upon request by calling the Member Services phone number on your member ID card. The summary will not include financial agreements as to actual rates, reimbursements, charges or fees negotiated by Aetna and the provider. The summary will include a category or type of compensation paid by Aetna to each class of health care provider under contract with Aetna.

Hawaii

Get a free printed directory

If you live in Hawaii, you may contact the Hawaii Insurance Division and the Office of Consumer Complaints at **808-586-2790**.

Informed consent

You have the right to be fully informed before making any decision about any benefit, treatment, or nontreatment. Your provider will do all of the following actions listed below.

- Discuss all treatment options, including the option of no treatment at all.
- Ensure that persons with disabilities have an effective means of communication with the provider and other members of the managed care plan.
- Discuss all risks, benefits and consequences of treatment and nontreatment.
- Discuss with you (and other covered family members) both living wills and durable powers of attorney in relation to medical treatment.

Illinois

Illinois law requires certain health plan disclosures

Illinois law requires health plans to provide the following information each year to enrollees and to prospective enrollees upon request: (1) a complete list of participating health care providers in the health care plan's service area; (2) a description of the service area; (3) the covered benefits and services with all exclusions, exceptions and limitations; (4) the precertification and other utilization review procedures and requirements; (5) a description of the process for the selection of a primary care physician, any limitation on access to specialists, and the plan's standing referral policy; (6) a description of the emergency coverage and benefits, including any restrictions on emergency care services; (7) out-of-area coverage and benefits, if any; (8) the enrollee's financial responsibility for copayments, deductibles, premiums and any other out-of-pocket expenses; (9) the provisions for continuity of treatment in the event a health care provider's participation terminates during the course of an enrollee's treatment by the provider; (10) the appeals process, forms and time frames for health care services appeals, complaints and external independent reviews, administrative complaints, and utilization review complaints, including a phone number to call to receive more information from the health care plan concerning the appeals process; (11) a statement of all basic health care services and all specific benefits and services to be provided to enrollees by a state law or administrative rule; (12) a description of the financial relationship between the health plan and any health care provider, including, if requested, the percentage of copayments, deductibles and total premiums spent on health care related expenses and the percentage of copayments, deductibles and total premiums spent on other expenses, including administrative expenses.

Indiana

Filing a complaint

Visit the complaint section of Indiana's state website at **IN.gov/idoi/2547.htm** to learn how you can file a complaint.

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Iowa

Coverage decisions

A "coverage decision" is defined as a final adverse decision because a product or service was not deemed medically necessary. This definition does not include a denial of coverage for a service or treatment specifically listed in a plan or evidence of coverage documents as excluded from coverage, or a denial of coverage for a service or treatment that has already been received and for which the enrollee has no financial liability.

Kansas

Kansas law requires plans to provide certain information

Kansas law permits you to have the following information upon request: (1) a complete description of the health care services, items and other benefits to which you are entitled in the particular health plan that is covering or being offered to you; (2) a description of any limitations, exceptions or exclusions to coverage in the health benefits plan, including prior-authorization policies, restricted drug formularies, or other provisions that restrict your access to covered services or items; (3) a listing of the plan's participating providers, their business addresses and telephone numbers, their availability, and any limitation on your choice of provider; (4) notification in advance of any changes in the health benefits plan that either reduces the coverage or increases the cost to you; and (5) a description of the grievance and appeal procedures available under the health benefit plan and your rights regarding termination, disenrollment, nonrenewal or cancellation of coverage. If you are a member, contact Member Services by calling the phone number on your member ID card to ask for more information. If you are not yet an Aetna® member, contact your plan administrator.

Kentucky

A provider's right to join the network

Any health care provider who meets our enrollment criteria and who is willing to meet the terms and conditions for participation has a right to become a participating provider in our network.

Direct access to a network chiropractic provider

You have direct access to the participating primary chiropractic provider of your choice. You don't need a referral from your primary care physician to access chiropractic benefits covered under your benefits plan.

Directory information, financial incentives and wait times

Kentucky law requires Aetna® to provide, upon enrollment and upon request, the following information: (1) a current participating provider directory with information on access to primary care providers and available providers; (2) general information on the type of financial incentives between contracted participating providers including any incentives and bonuses; and (3) our standard customary waiting times for appointments for urgent and routine care. Our customary wait times are for routine care (within 7 days); preventive care (within 8 weeks); symptomatic, urgent care (within 3 days) and urgent complaint (same day or within 24 hours) and emergency care (immediately or referred to an emergency room.)

Additionally, upon request, we will make available information about the provider network, including hospital affiliations and whether a particular network provider is board certified and whether a provider is currently accepting new patients. Members may contact Member Services at the phone number on their member ID card for more information; all others, contact your benefits administrator.

Definition of "emergency medical condition"

An emergency medical condition is a medical condition that manifests itself with acute symptoms of sufficient severity, including severe pain, that a prudent layperson would reasonably have cause to believe constitutes a condition that the absence of immediate medical attention could reasonably be expected to result in: placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, a situation in which there is inadequate time to effect a safe transfer to another hospital before delivery; or a situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.

Louisiana

You may receive care at a network hospital by a provider who is not in your plan's network

Health care services may be provided to you at a network health care facility by facility-based physicians who are not in your health plan. You may be responsible for payment of all or part of the fees for those out-of-network services, in addition to applicable amounts due for copayments, coinsurance, deductibles, and noncovered services. Specific information about in-network and out-of-network facility-based-physicians can be found at the website address of your health plan or by calling the customer service telephone number of your health plan.

Michigan

Get a free printed directory

Michigan members may contact the Michigan Office of Financial and Insurance Services at **517-284-8800** to verify participating providers' licenses and access information on formal complaints and disciplinary actions filed or taken against a health care provider in the preceding three years. For more information on your health plan, call **1-800-208-8755 (TTY: 711)** or refer to your plan documents.

North Carolina

Obstetrician-gynecologist (Ob/Gyn) visits

Any female member who is 13 or older may visit any participating OB/Gyn for:

- A routine well-woman exam (including a Pap smear, when appropriate)
- An unlimited number of visits for gynecological problems
- An unlimited number of visits for follow-up care

Members may be able to pay in-network cost sharing for out-of-network services

If you cannot get a medically necessary service or supply through a participating doctor or hospital without unreasonable delay, or you can't find a participating doctor who can provide the service or supply, you can get the service or supply from a nonparticipating provider. You must precertify the service or supply first. Once precertified, we will cover the service or supply at the in-network benefit level. That means your share of the costs — the copayment, coinsurance, and/or deductible, if applicable — will be at the in-network level. This is also true for medical emergencies. Medical emergencies do not require precertification.

Oklahoma

Filing claims

Aetna network doctors and other health care providers will file claims for you. However, you may need to file a claim for covered out-of-network services. Go to **Aetna.com/individuals-families/using-your-aetna-benefits/find-form.html** to download and print a claim form. You can also call the phone number on your member ID card to ask for a claim form. The claim form includes complete instructions including what documentation to send with it. We determine how and whether a claim is paid based on the terms and conditions of the health coverage plan and our internal coverage policies.

Oklahoma Breast Cancer Patient Protection Act

In addition to the benefits provided under the Women's Health and Cancer Rights Act of 1998, the Oklahoma Breast Cancer Patient Protection Act requires plans to provide the following benefits:

- For members who receive benefits for a medically necessary mastectomy, the plan must also cover at least 48 hours of inpatient care after the mastectomy, unless the member and attending doctor determine that a shorter hospital stay is appropriate.
- For members who receive a lymph node dissection, the plan must cover at least 24 hours of inpatient care after the lymph node dissection, unless the member and attending doctor determine that a shorter hospital stay is appropriate.
- For members who receive benefits for a medically necessary partial or total mastectomy, the plan must cover reconstructive breast surgery performed as a result of the mastectomy, except as prohibited by federal laws or regulations pertaining to Medicaid. When the reconstructive surgery is performed on a diseased breast, the plan will cover all stages of reconstructive surgery performed on a nondiseased breast to establish symmetry with the diseased breast. Adjustments made to the nondiseased breast must occur within 24 months of reconstruction of the diseased breast.

Oregon

Coverage of contraceptives and other services, drugs, devices, products and procedures

Oregon health benefit plans provide comprehensive reproductive health care coverage. Coverage includes:

- Well-woman care
- Counseling for sexually transmitted infections, including, but not limited to, human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS)
- Screening for the following conditions:
  - a. Chlamydia
  - b. Gonorrhea
  - c. Hepatitis B
  - d. Hepatitis C
  - e. HIV and AIDS
  - f. Human papillomavirus
  - g. Syphilis
  - h. Anemia
  - i. Urinary tract infection
  - j. Pregnancy
  - k. Rh incompatibility
  - l. Gestational diabetes

m. Osteoporosis

n. Breast cancer

o. Cervical cancer

- Screening to determine whether counseling related to the BRCA1 or BRCA2 genetic mutations is indicated, and, if indicated, counseling related to the BRCA1 or BRCA2 genetic mutations
- Screening and appropriate counseling or interventions for tobacco use, and domestic and interpersonal violence
- Folic acid supplements
- Abortion
- Breastfeeding comprehensive support, counseling, and supplies
- Breast cancer chemoprevention counseling
- Contraceptive drugs, devices, or products approved by the FDA
- Voluntary sterilization

Coverage is generally provided with no deductible or cost-sharing, unless you are covered under a qualified high-deductible health plan. However, if you are covered under a group plan purchased by a religious employer, your employer may elect to not include coverage for contraceptives or abortion procedures. Please refer to your Summary of Benefits and Coverage document or health benefits booklet for a complete description of your reproductive health care coverage.

Rhode Island

All Payer Claims Database (APCD)

The Rhode Island All Payer Claims Database (APCD) provides reports about health care quality, cost and reforms. Policymakers will use it to help them make better decisions regarding health care quality. All health insurers in Rhode Island send information to the APCD. All information sent to the APCD is anonymous. To maintain your privacy, we will not send any of the following to the APCD: your name, address, telephone number, email address, Social Security number, or any other information that could identify you.

You can exclude your information from the APCD. To do so, go to **RIAPCD-OptOut.com** or call Rhode Island Health Insurance Consumer Support toll-free at **1-855-747-3224**.

Questions?

- Email: Rhode Island All Payer Claims Database at **OHIC.RIAPCD@ohic.ri.gov**
- Phone: Rhode Island Health Insurance Consumer Support toll-free at **1-855-747-3224**

Tennessee

Routine vision care

You're covered for routine vision exams from participating providers without a referral from your primary care physician. Copayments may apply. For routine eye exams, you can visit a participating optometrist or ophthalmologist without a referral, once every 12 months. A contact lens fitting exam is not covered.

West Virginia

Contraceptive drugs and devices

Plans that include prescription drug benefits must have a rider that covers birth control products that are approved by the U.S. Food and Drug Administration. Religious employers are allowed to opt out of this coverage. If that happens, members covered under the contract can get their own birth control rider directly from us. Talk to your plan administrator to see if this impacts you.

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)

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