In compliance with the laws of New Jersey and federal laws and regulations, we are pleased to provide you with the following notice about your plan coverage.

Questions?

Here's how to reach us. You can either:

- Go to your personal member website at **Aetna.com**
- Forgot your user name or password? Call us at Member Services using the toll-free number on your ID card

Note: Don't have internet access? Ask us for a copy of this document and a printed list of doctors and other providers.

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

It's important to know which doctors are in our network. That's because some health plans only provide coverage for doctors, hospitals and other health care providers if they are in our network. Some plans provide coverage for outside of the network. But you pay less when you visit doctors in the network.

Here's how you can find out if your health care provider is in our network

- Go to **Aetna.com**, your personal member website, and log in. Follow the path to find a doctor and enter your doctor's name in the search field.
- Call us at the toll-free number on your Aetna member ID card at **1-888-87-Aetna (TTY: 711)** or **1-888-872-3862 (TTY: 711)**.

If you would like a printed list of doctors, call us at the toll-free number on your Aetna member ID card.

Our online directory is more than just a list of doctors' names and addresses. It also includes information about:

- Where the doctor attended medical school
- Board certification status
- Language spoken
- Hospital affiliations
- Gender

You can even get driving directions. If you don't have internet access, call us to ask about this information.

How Aetna compensates your health care provider

All the physicians are independent practicing physicians who are neither employed — nor exclusively contracted — with Aetna. Individual physicians and other providers are in the network by either directly contracting with us and/or affiliating with a group or organization that contracts with us.

In-network providers are compensated in various ways:

- Per individual service or case, at contracted rates (a fee-for-service basis)
- Per hospital, per day at contracted rates (a per diem basis)
- A prepaid amount per member, per month (a capitation basis)
- Through integrated delivery systems (IDSs), independent practice associations (IPAs), physician hospital organizations (PHOs), physician medical groups (PMGs), behavioral health organizations, or other similar provider organizations or groups. We pay these organizations directly. Then, they may reimburse the physician, provider organization or facility, directly or indirectly, for covered services. In such arrangements, the group or organization has a financial incentive to control the cost of care.
- Behavioral health network providers participate through a behavioral health organization. Aetna pays these organizations on a capitation basis. The organization reimburses the physician, provider organization or facility on either a fee-for-service or a per-diem basis, for covered services.

One purpose of managed care is to manage the cost of health care. Incentives in compensation arrangements with physicians and health care providers are one method by which Aetna attempts to achieve this goal.

If you need more information about how we pay primary care physicians or any other provider in our network, please contact us by:

- Phone: use the toll-free number on your member ID card
- Mail: Aetna Health Inc., 9 Entin Road, Parsippany, NJ 07054

03.28.323.1-NJ D (3/22)

Doctors, chiropractors and podiatrists must inform you of certain financial interests

Some doctors make referrals to other health care providers. They may refer you to doctors or facilities in which they have a significant financial interest. While they are allowed to do that, they must tell you about their financial interest at the time of the referral. If you want more information about this, contact your physician, chiropractor or podiatrist. If you believe that you are not receiving the information to which you are entitled, contact the Division of Consumer Affairs in the New Jersey Department of Law and Public Safety at **1-973-504-6200** or **1-800-242-5846**.

Physician board certification

As of 2022, 78% of our in-network physicians are board certified. If you would like to know if a specific physician is board certified, or is currently accepting new patients, call us at the toll-free number on your member ID card.

Appointment waiting times

We expect members who need an appointment with their primary care physician (PCP) to be seen in a timely manner, as described below.

- Urgent care: same day or within 24 hours
- Nonurgent symptomatic care: within 3 days
- Nonurgent routine care: within 7 days
- Nonurgent preventive care: within 8 weeks

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 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 get precertification, 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.

To be covered, you must get the precertification before you receive the care. To begin the process, call the toll-free number on your member ID card.

Note: You do not have to get precertification for emergency services.

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. Second, we make sure the service and 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. Third, we look to see if you qualify for one of our case management programs. If so, one of our nurses may contact you.

Note: Have you reached any plan dollar limits or visit maximums for a particular service? If so, even if you get precertification for that service, it may not be covered.

Your costs when you go outside of the network

You may be enrolled under a point-of-service plan, which means the plan covers health care services when provided by a doctor who participates in the Aetna network (also referred to as "in-network" benefits). The plan also covers health care services when provided by a doctor who does not participate in the Aetna network (also referred to as "out-of-network benefits"). If you are admitted to a network health care facility by an out-of-network provider, care you receive from an admitting or attending out-of-network provider while you are there will be covered under the plan at the out-of-network level of benefits. You will be responsible for applicable out-of-network copayments, coinsurance and deductibles.

Over-age dependents

If you are a parent of an over-age dependent who is actively covered under a New Jersey-issued group health contract, your dependent may be eligible for coverage to age 31 if you meet the eligibility requirement and elect coverage. For more information, please contact your employer, refer to your plan documents, or call us at the toll-free number on your Aetna member ID card.

Organ and tissue donation

Each year, we’re required to send you informational materials about organ and tissue donation and registration. This is required,* as your health benefits plan is written in New Jersey.

For information on how to make an anatomical gift, including information on the registration of a gift in the

Donate Life New Jersey registry, please use the following contact information, depending on where you live.

Northern or central New Jersey residents:

- Mail:
  New Jersey Sharing Network
  691 Central Avenue,
  New Providence, NJ 07974
- Phone: **1-800-742-7365**
- Email: **Info@NJSharingNetwork.org**
- Web: **NJSharingNetwork.org**

Southern New Jersey residents:

- Mail:
  Gift of Life Donor Program
  401 N. 3rd Street
  Philadelphia, PA 19123
- Phone: **1-800-Donors-1** or **1-800-366-6771**
- Email: **Info@Donors1.org**
- Website: **Donors1.org**

Residents in other states:

- Website:
  OrganDonor.Gov/Awareness/Organizations/Local-OPO.html

What to do if you disagree with us

Complaints, appeals and external reviews

We have procedures for you to use if you are dissatisfied with a decision that we made or with our operations.The procedure you need to follow will depend on the type of issue or problem you have.

Adverse benefit determinations

Adverse benefit determinations are decisions that result in denial, reduction, or termination of a benefit or the amount paid for it. It also means a decision not to provide a benefit or service. Adverse benefit determinations can be made for utilization review and denials — we determine that the service or supply is not medically necessary, is an experimental or investigational procedure, or is for dental or cosmetic purposes.

All adverse benefit determinations to deny or limit an admission, service, procedure or extension of stay will be made by a physician. You will receive written notice of an adverse benefit determination within the time frames shown in this document.

Under certain circumstances, the time frames may be extended. The written notice will provide important information that will help you in making an appeal of the adverse benefit determination, if you wish to do so.

Urgent care or pre-service claim appeal

If your claim is an urgent claim or a pre-service claim, your provider may appeal for you without having to fill out an appeal form. We will answer urgent utilization review claim appeals within 36 hours for level one and two appeals and within [24-72 hours] for an initial determination. We will answer utilization review pre-service claims within 15 calendar days. We will answer utilization review pre-service claim appeals within 10 calendar days for level one appeals and within 15 calendar days for level two appeals. There are no extensions for urgent care utilization review claims. Extensions for pre-service claim utilization are 15 days. The additional information request timeframe for urgent care utilization review claims is [24-72 hours]. The additional information request timeframe for pre-service claim utilization review is 15 days. Responses to additional information requests are required within 48 hours for urgent care utilization claims and within 45 days for pre-service utilization claims.

A concurrent claim appeal will be addressed according to what type of service and claim it involves. We will answer urgent concurrent care claims within 24 hours if received at least 24 hours before the previously approved health care services end. Non-urgent concurrent care utilization claim review timeframes are 15 calendar days.

*This notice is sent in compliance with Chapter 220 of the New Jersey Laws of 2017.

The chart below summarizes some information about how different types of claims are handled.

Time frames for notification of an adverse benefit determination

Type of claim	Response time from receipt of claim
Urgent care claim A claim for medical care or treatment for which a delay could seriously jeopardize the life or health of the member, the ability of the member to regain maximum function or subject the member to severe pain that cannot be adequately managed without the requested care or treatment	As soon as possible but not later than 72 hours
Concurrent care claim extension A request to extend a course of treatment that was previously pre-authorized by Aetna	• If an urgent care claim, as soon as possible but not later than 24 hours • If a nonurgent care claim, within 15 calendar days
Concurrent care claim reduction or termination A decision to reduce or terminate a course of treatment previously pre-authorized by us (we will not deny coverage based on medical necessity for previously approved services, unless the approval was based on material misrepresentation or fraudulent information submitted by the covered person or provider)	With enough advance notice to allow the member to appeal
Preservice claim A claim for a benefit that requires pre-authorization of the benefit before getting medical care	Within 15 calendar days
Postservice claim A claim for a benefit that is not a preservice claim	Within 30 calendar days

Time frames for responding to an adverse benefit determination appeal (starts when we receive the appeal)

Type of claim	Level-one appeal	Level-two appeal
Urgent care claim A claim for medical care or treatment where a delay could seriously jeopardize the the member's life, health, or ability to regain maximum function, or subject the member to severe pain that cannot be adequately managed without the requested care or treatment	Within 36 hours (review will be provided by Aetna personnel who were not involved in making the adverse benefit determination)	Within 36 hours (review will be provided by the Aetna Appeals Committee)
Concurrent care claim extension A request to extend, or a decision to reduce, a previously approved course of treatment	Treated like an urgent care claim (within 36 hours) or a preservice claim (within 10 calendar days), depending on the circumstances	Treated like an urgent care claim (within 36 hours) or a preservice claim (within 15 calendar days), depending on the circumstances
Preservice claim A claim for a benefit that requires approval of the benefit before getting medical care	Within 10 calendar days (review will be provided by Aetna personnel who were not involved in making the adverse benefit determination)	Within 15 calendar days (review will be provided by the Aetna Appeals Committee)
Postservice claim Any claim for a benefit that is not a preservice claim	Within 10 calendar days (review will be provided by Aetna personnel who were not involved in making the adverse benefit determination)	Within 20 business days (review will be provided by the Aetna Appeals Committee)

(A) Complaints

A complaint is an expression of dissatisfaction about the quality of care or our operation.

If you are not satisfied with the administrative services you have received from Aetna or want to complain about a participating provider, please call or write to us. You'll need to:

- Give us a detailed description of the matter
- Send copies of any records or documents that you think may help or be relevant to the matter

We will review the information and send you a written response within 30 calendar days of our receipt of the complaint. We may take longer to send you a response if we need more information and this information cannot be obtained within the original 30 days. The response will let you know what you will need to do to seek an additional review.

(B) Appeals of adverse benefit determinations

An appeal is a request to Aetna to reconsider an adverse benefit determination. The appeal procedure for an adverse benefit determination has two levels.

We will send written notice of an adverse benefit determination. The notice will:

- Tell you why we made our decision
- Explain the next steps you must take if you want to appeal
- Identify your rights to receive additional information that may be relevant to your appeal

Important: You must make your appeal by phone or in writing within 180 calendar days from the date of the notice.

If you are dissatisfied with a utilization management adverse benefit determination, you (or a provider acting on your behalf and with your consent) will have the opportunity to appeal.

We provide two levels of appeal of the adverse benefit determination. You must complete the two levels of review before you pursue an appeal to an independent utilization review organization (IURO).

If you decide to appeal to the second level, the request must be made in writing within 60 calendar days from the date of our notice. The level-one appeal result will include information about how to make a level-two appeal. Within 10 business days of our receipt of a level-two appeal, we will acknowledge the appeal in writing.

The level-one appeal review will be conducted by a physician who was neither the original reviewer, nor a subordinate of the original reviewer.

For a level-two appeal, we will conduct a same or similar specialty review for appeals involving clinical issues. In no event, however, will the consulting practitioner or professional have been involved in the utilization management determination at issue.

We maintain a formal level-two internal utilization management appeal process. In this process, any member (or provider acting on behalf of a member with the member's consent) who is dissatisfied with the results of a level-one appeal, will have the opportunity to pursue the appeal before a panel of physicians and/or other health care professionals selected by Aetna. The panel will not include anyone who was involved in any of the previous utilization management decisions. The member (and/or an authorized representative) may attend the level-two appeal hearing, question the Aetna representatives, and present her or his case.

(C) Exhaustion of process

You are not required to use up internal appeals before you complain to the Department of Banking and Insurance. The department's ability to investigate a complaint will not be limited by any exhaustion.

If we fail to comply with any of the deadlines for completion of the level-one appeal or level-two appeal, or if we, for any reason, expressly waive our rights to an internal review of any appeal, then you and/or your provider have the option to proceed directly to the external appeals process described in the External Appeal Process section.

(D) External appeal process

A covered person or a provider, acting with the consent of the covered person, has the right to contest a utilization management (UM) denial through internal and external appeals.

In an internal appeal, the covered person (or the provider, with the consent of the covered person) submits a request to the insurance company to reverse a UM denial, i.e. a denial of a claim or an authorization that is based on a lack of medical necessity. The request should explain why the covered person and/or provider believe the denial was inappropriate.

An external appeal is a request to an independent

utilization review organization (IURO) to reverse a UM denial, generally following an unsuccessful internal appeal or appeals.

An IURO is an organization of medical professionals that is not part of or affiliated with an insurance company. In New Jersey, the Department of Banking and Insurance contracts with IUROs to review internal appeals and render decisions on external appeal requests submitted by persons covered by fully-insured health benefits plans issued in New Jersey.

Covered persons should state in both their internal and external appeal requests whether they want their appeal processed on an expedited basis and the reasons they believe expedited treatment is warranted.

A request for an external appeal must typically be filed within four months of receipt of the decision on the internal appeal. The covered person or provider should electronically file the request for external appeal by providing the information requested at:
https://njihcap.maximus.com/

Persons who are unable to submit a request for an external appeal electronically can download and print the appeal from the Maximus website above. Persons may also contact Maximus and ask that an appeal form be sent to them by regular mail and/or by fax. The completed appeal form may be returned to Maximus by fax at: **585-425-5296**;

(1) Or Mail: Maximus Federal – NJ IHCAP, 3750 Monroe Avenue, Suite 705, Pittsford, New York 14534 Questions about the application process can be directed to Maximus Federal by calling **888-866-6205** or e-mailing **Stateappealseast@maximus.com**.

(2) The covered person or provider should include with the request for an IURO appeal:

(3) All information submitted to the Insurance company

(4) Any additional information the covered person or provider wants considered by the IURO

(5) The insurance company's initial UM denial

(6) The insurance company's decision(s) on the internal appeal(s).

(7) The fee for filing an appeal is $25.The filing fee will be waived if you submit evidence of participation in one of the following: Pharmaceutical Assistance to the Aged and Disabled, NJ FamilyCare (Medicaid), General Assistance, SSI, or New Jersey Unemployment Assistance.

(8) When the Department of Banking and Insurance receives the appeal, together with the executed release and the appropriate fee, it will immediately assign the appeal to an IURO.

(9) When the IURO receives the request for appeal from the Department of Banking and Insurance, it will conduct a preliminary review of the appeal and accept it for processing, if they determine that:

- The individual was, or is, a member of Aetna
- The service that is the subject of the complaint or appeal reasonably appears to be a covered benefit under the Certificate of Coverage
- The member has fully complied with both the level-one and level-two appeal processes
- The member has provided all information required by the IURO and the Department of Banking and Insurance to make the preliminary determination, including the appeal form and a copy of any information we provided regarding our decision to deny, reduce, or terminate the covered benefit, a fully executed release to obtain any necessary medical records from us, and any other relevant health care provider

(10) When the IURO receives the request for appeal from the Department of Banking and Insurance, it will conduct a preliminary review of the appeal and accept it for processing, if it determines that:

- The individual was or is a member of Aetna
- The service that is the subject of the complaint or appeal reasonably appears to be a covered benefit under the Certificate of Coverage
- The member has fully complied with both the level-one and level-two appeal processes
- The member has provided all information required by the IURO and the Department of Banking and Insurance to make the preliminary determination, including the appeal form and a copy of any

information we provided regarding our decision to deny, reduce, or terminate the covered benefit, a fully executed release to obtain any necessary medical records from us, and any other relevant health care provider

(11) Within five business days of receipt of the request from the Department of Banking and Insurance, the IURO will complete the preliminary review and notify the member (and/or provider), in writing, of whether the appeal has been accepted for processing. If the appeal is not accepted, the reason(s) will be included in the written notice. The IURO will additionally notify the individual (and/or provider) of her or his right to submit in writing, within five business days of the receipt of acceptance of the appeal, any additional information to be considered in the IURO's review.

(12) When the IURO accepts the appeal for processing, it will conduct a full review to determine whether, as a result of our utilization management determination, the member was deprived of medically necessary covered benefits. In reaching this determination, the IURO will take into consideration all pertinent medical records, consulting physician reports, and other documents submitted by the parties; any applicable, generally accepted practice guidelines developed by the federal government and national or professional medical societies, boards and associations; and any applicable clinical protocols and/or practice guidelines we have developed.

(13) The full review referenced in this document will initially be conducted by a either a registered nurse or a physician who is licensed to practice in New Jersey. When necessary, the IURO will refer all cases for review to a consultant physician in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the appeal. All final recommendations of the IURO will be approved by the medical director of the IURO.

(14) The IURO will complete its review and issue its recommended decision as soon as possible (but not to exceed 45 days from the receipt of all documentation necessary to complete the review) in accordance with the medical urgency of the case. The IURO may, however, extend its review for a reasonable period of time as may be necessary due to circumstances beyond its control. If that happens, then, the IURO shall, prior to the conclusion of the preliminary review, provide written notice to the member, to the Department of Banking and Insurance, and to Aetna, explaining both the status of its review and the specific reasons for the delay.

(15) If the IURO determines that the member was deprived of medically necessary covered benefits, the IURO will recommend to the member, Aetna, and the New Jersey Department of Health and Senior Services what appropriate, covered health care services the member should receive.

(16) Once the review is complete, we will abide by the decision of the IURO.

(17) The filing fee will be refunded to you (or the health care provider) if the IURO reverses our final internal adverse benefit determination.

(18) We pay the costs of the IURO's preliminary review and full review, regardless of the outcome.

(E) Record retention

We will keep all records about your complaints and appeals for at least seven years.

(F) Fees and costs

Except as described in numbers 10 and 11 of the "External appeal process" section in this document, for an external appeal, Aetna is not responsible for any legal fees or any other fees you incur if you pursue a complaint or appeal.

(G) Addresses and phone numbers

- Aetna mail:
  Aetna Complaints and Appeals
  PO Box 14596
  Lexington, KY 40512
- Aetna phone: **1-888-982-3862 (TTY: 711)** or the toll-free number on the member ID card
- New Jersey state government mail:
  New Jersey Department of Banking and Insurance
  Office of Managed Care
  PO Box 329 (Courier: 20 West State Street)

Trenton, NJ 08625-0329

- New Jersey state government phone: **1-888-393-1062**

Independent consumer satisfaction surveys

You may request independent consumer satisfaction results and an analysis of quality outcomes of health care services of managed care plans in New Jersey. For a copy of the guide, contact New Jersey state government via any of the ways below.

- Mail:

  New Jersey Department of Banking and Insurance

  PO Box 325

  Trenton, NJ 08625-0325

  (Courier: 20 West State Street)
- Phone: **1-888-393-1062**
- Website:

  State.NJ.US/dobi/division_consumers/insurance/health.htm (select "NJ HMO and PPO Performance Report")

New Jersey Quitnet and New Jersey Quitline

Tobacco products pose a serious health threat in New Jersey, and cost the health insurance industry millions of dollars annually. The New Jersey Department of Health and Senior Services provides two free services to consumers to help kick the tobacco habit:

1. New Jersey Quitline at **1-866-NJ-Stops** or

   1-866-657-8677

   This organization provides individualized telephone-based counseling and referral programs for people who want to quit smoking.
2. New Jersey Quitnet at **NJQuitline.org** This organization provides online, personalized support and referrals.

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**), **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)**.

03.28.323.1-NJ D (3/22)

TTY: 711

English	To access language services at no cost to you, call the number on your ID card.
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Persian Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.

03.28.323.1-NJ D (3/22)