PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H0523

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	97.61%
Request denied	2.39%
Request approved after appeal	53.33%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	97.06%
Request denied	2.94%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	3.06 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.54 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H0562

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	100.00%
Request denied	0.00%
Request approved after appeal	N/A

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	N/A
Request denied	N/A

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	2.00 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	N/A	N/A

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H0628

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	92.32%
Request denied	7.68%
Request approved after appeal	89.47%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	86.34%
Request denied	13.66%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.28 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.32 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H1109

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	92.32%
Request denied	7.68%
Request approved after appeal	82.61%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	93.06%
Request denied	6.94%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.39 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.14 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H1206

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	94.04%
Request denied	5.96%
Request approved after appeal	87.18%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	94.05%
Request denied	5.95%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.17 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.20 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H1608

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	91.83%
Request denied	8.17%
Request approved after appeal	92.40%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	87.46%
Request denied	12.54%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.45 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.33 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H1609

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	89.64%
Request denied	10.36%
Request approved after appeal	83.79%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	88.22%
Request denied	11.78%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.50 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.25 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H1692

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	90.41%
Request denied	9.59%
Request approved after appeal	90.69%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	83.53%
Request denied	16.47%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.47 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.37 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H2056

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	92.78%
Request denied	7.22%
Request approved after appeal	88.46%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	90.35%
Request denied	9.65%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.50 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.38 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H2293

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	91.71%
Request denied	8.29%
Request approved after appeal	88.86%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	85.40%
Request denied	14.60%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.53 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.32 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H2663

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	93.23%
Request denied	6.77%
Request approved after appeal	90.12%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	89.01%
Request denied	10.99%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.24 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.29 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H3146

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	92.91%
Request denied	7.09%
Request approved after appeal	86.28%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	90.36%
Request denied	9.64%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.33 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.32 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H3152

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	94.50%
Request denied	5.50%
Request approved after appeal	81.20%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	91.75%
Request denied	8.25%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.06 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.24 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H3192

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	90.63%
Request denied	9.37%
Request approved after appeal	85.30%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	86.61%
Request denied	13.39%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.60 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.34 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6671.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H3219

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	88.53%
Request denied	11.47%
Request approved after appeal	80.43%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	86.86%
Request denied	13.14%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	2.28 day(s)	1 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.65 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0130_NR_7694200_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H3239

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	89.59%
Request denied	10.41%
Request approved after appeal	84.71%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	85.32%
Request denied	14.68%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.69 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.38 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H3288

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	89.06%
Request denied	10.94%
Request approved after appeal	90.48%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	85.47%
Request denied	14.53%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.66 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.41 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H3312

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	92.69%
Request denied	7.31%
Request approved after appeal	82.33%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	85.40%
Request denied	14.60%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.30 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.45 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H3597

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	94.54%
Request denied	5.46%
Request approved after appeal	91.25%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	92.23%
Request denied	7.77%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.15 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.23 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H3748

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	92.72%
Request denied	7.28%
Request approved after appeal	90.62%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	92.00%
Request denied	8.00%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.47 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.18 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H3928

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	89.58%
Request denied	10.42%
Request approved after appeal	87.10%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	81.43%
Request denied	18.57%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.54 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.43 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H3931

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	90.50%
Request denied	9.50%
Request approved after appeal	87.93%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	85.03%
Request denied	14.97%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.68 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.41 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H3959

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	93.95%
Request denied	6.05%
Request approved after appeal	87.59%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	90.55%
Request denied	9.45%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.11 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.27 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H4523

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	87.27%
Request denied	12.73%
Request approved after appeal	88.96%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	83.56%
Request denied	16.44%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.80 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.33 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H4711

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	88.70%
Request denied	11.30%
Request approved after appeal	86.71%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	85.21%
Request denied	14.79%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.93 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.38 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H4835

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	89.31%
Request denied	10.69%
Request approved after appeal	88.46%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	80.74%
Request denied	19.26%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.81 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.47 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H4982

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	97.96%
Request denied	2.04%
Request approved after appeal	56.58%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	97.21%
Request denied	2.79%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	2.30 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.37 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H5302

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	92.56%
Request denied	7.44%
Request approved after appeal	85.65%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	86.65%
Request denied	13.35%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.29 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.30 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H5309

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	83.66%
Request denied	16.34%
Request approved after appeal	95.37%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	75.27%
Request denied	24.73%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	2.71 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.33 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H5325

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	91.32%
Request denied	8.68%
Request approved after appeal	83.73%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	86.82%
Request denied	13.18%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.47 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.33 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H5337

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	93.41%
Request denied	6.59%
Request approved after appeal	N/A

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	N/A
Request denied	N/A

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	0.86 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	N/A	N/A

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H5521

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	92.14%
Request denied	7.86%
Request approved after appeal	89.70%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	89.13%
Request denied	10.87%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.44 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.32 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H5522

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	93.03%
Request denied	6.97%
Request approved after appeal	90.32%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	89.05%
Request denied	10.95%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.28 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.29 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H5593

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	93.00%
Request denied	7.00%
Request approved after appeal	85.71%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	83.96%
Request denied	16.04%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.36 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.66 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H5793

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	94.22%
Request denied	5.78%
Request approved after appeal	86.22%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	87.12%
Request denied	12.88%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.13 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.38 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H7149

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	92.24%
Request denied	7.76%
Request approved after appeal	88.55%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	86.91%
Request denied	13.09%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.53 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.38 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H7301

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	93.98%
Request denied	6.02%
Request approved after appeal	89.77%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	88.49%
Request denied	11.51%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.21 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.28 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H8332

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	86.82%
Request denied	13.18%
Request approved after appeal	72.22%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	84.31%
Request denied	15.69%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.46 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.43 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H8597

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	87.35%
Request denied	12.65%
Request approved after appeal	86.35%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	83.74%
Request denied	16.26%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.79 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.38 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H8649

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	89.83%
Request denied	10.17%
Request approved after appeal	90.34%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	85.47%
Request denied	14.53%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	1.93 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.46 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: H9431

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	80.14%
Request denied	19.86%
Request approved after appeal	93.75%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	85.71%
Request denied	14.29%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	2.67 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.14 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_NR_7577500_2026_C

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To follow new federal rules, Aetna must share certain information each year on our website.

We must post a list of all medical items and services (not including medicines) that need prior authorization. We also have to share numbers from the past year that show how many prior authorization requests we got, how many were approved, and how many were denied. Sharing this information helps everyone see how the process works. It also helps patients understand what to expect and lets doctors compare how different health plans perform.

If you have questions about the information below, please contact: 1-833-570-6670.

Reporting Period: 2025
Product: Medicare Advantage
Contract: R6694

These are the medical items and services for which we require prior authorization (excluding drugs)

2025 Participating provider precertification list for Aetna

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframe:

- For Medicare Advantage plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires Medicare Advantage plans and applicable integrated plans to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent) and 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	Percentage
Request approved	94.54%
Request denied	5.46%
Request approved after appeal	94.74%

Expedited (urgent) Prior Authorization Requests (Response Due to Provider Within 72 Hours)

	Percentage
Request approved	93.48%
Request denied	6.52%

Prior Authorizations Extended and Approved

	Percentage
Request approved after time for review was extended	N/A

Time Between Receiving a Prior Authorization Request and Determination

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 14 calendar days)	0.96 day(s)	0 day(s)
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	0.22 day(s)	0 day(s)

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

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