Important information about your health benefits

For Traditional Choice® indemnity plans.

Understanding your plan of benefits

Aetna* health benefits plans cover most types of health care from a doctor or hospital. But they do not cover everything. The plan covers recommended preventive care and care that you need for medical reasons. It does not cover services you may just want to have, like plastic surgery. It also does not cover treatment that is not yet widely accepted. You should also be aware that some services may have limits. For example, a plan may allow only one eye exam per year.

Warning: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

Not all of the information in this booklet applies to your specific plan
Most of the information in this booklet applies to all plans. But some does not. For example, not all plans have deductibles or prescription drug benefits. Information about those topics will only apply if your plan includes those provisions.

State-specific information throughout this booklet does not apply to all plans. To be sure, review your plan documents, ask your benefits administrator, or call Aetna Member Services.

Where to find information about your specific plan
Your plan documents list all the details for your plan, such as what's covered, what's not covered and the specific amounts you will pay for services. Plan document names vary. They may include a Booklet-certificate, Group Agreement and Group Insurance Certificate, Group Policy and/or any riders and updates that come with them.

If you can't find your plan documents, call Member Services to ask for a copy. Use the toll-free number on your Aetna ID card.

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* Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. Health benefits and health insurance plans are provided, underwritten or administered by Aetna Life Insurance Company.

www.aetna.com

Getting help

Contact us

Member Services can help with your questions. To contact Member Services, call the toll-free number on your ID card. You can also send Member Services an e-mail. Just go to your secure Aetna Navigator® member website at **www.aetna.com**. Click on "Contact Us" after you log on.

Member Services can help you:

- Understand how your plan works or what you will pay
- Get information about how to file a claim
- File a complaint or appeal
- Get copies of your plan documents
- Connect to behavioral health services (if included in your plan)
- Find specific health information
- Learn more about our Quality Management program
- And more

Help for those who speak another language and for the hearing impaired

Do you need help in another language? Member Services representatives can connect you to a special line where you can talk to someone in your own language. You can also get interpretation assistance for registering a complaint or appeal.

Language hotline – **1-888-982-3862** *(140 languages are available. You must ask for an interpreter.)*

TDD **1-800-628-3323** *(hearing impaired only)*

Ayuda para las personas que hablan otro idioma y para personas con impedimentos auditivos

¿Necesita ayuda en otro idioma? Los representantes de Servicios al Miembro le pueden conectar a una línea especial donde puede hablar con alguien en su propio idioma. También puede obtener asistencia de un intérprete para presentar una queja o apelación.

Línea directa: **1-888-982-3862** *(Tenemos 140 idiomas disponibles. Debe pedir un intérprete.)*

TDD **1-800-628-3323** *(sólo para personas con impedimentos auditivos)*

Costs and rules for using your plan

What you pay

You will share in the cost of your health care. These are called "out-of-pocket" costs. Your plan documents show the amounts that apply to your specific plan. Those costs may include:

- Copay – A fixed amount (for example, $15) you pay for covered a health care service. You usually pay this when you receive the service. The amount can vary by the type of service. For example, the copay for your primary doctor's office visit may be different than a specialist's office visit.
- Coinsurance – Your share of the costs of a covered service. Coinsurance is calculated as a percent (for example, 20%) of the allowed amount for the service. For example, if the health plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health plan pays the rest of the allowed amount.
- Deductible – Some plans include a deductible. This is the amount you owe for health care services before your health plan begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you have paid $1,000 for any covered health care services that are subject to the deductible. The deductible may not apply to some preventive services, such as an annual physical or mammogram. Other deductibles may apply at the same time:
  - Inpatient Hospital Deductible – This deductible applies when you are a patient in a hospital.
  - Emergency Room Deductible – This is the amount you pay when you go to the emergency room. If you are admitted to the hospital within 24 hours, you won't have to pay it.

  The Inpatient Hospital and Emergency Room Deductibles are separate from your general deductible. For example, your plan may have an overall $1,000 deductible and also has a $250 Emergency Room Deductible. This means that you pay the first $1,000 before the plan pays anything. Once the plan starts to pay, if you go to the emergency room you will pay the first $250 of that bill.

Your plan pays for your health care using a "prevailing" or "reasonable" charge that we get from an industry database. Your doctor or hospital sets the rate it will charge you. It may be higher — sometimes much higher — than what your Aetna plan recognizes or allows based on the "prevailing" or "reasonable" charge. Your doctor may bill you for the dollar amount that Aetna doesn't recognize. You must also pay any coinsurance and deductibles under

your plan. No dollar amount above the recognized charge counts toward your deductible or out-of-pocket limits.

This means that you are fully responsible for paying everything above the amount that Aetna allows for a service or procedure. See "Emergency and urgent care and care after office hours" for more.

Precertification: Getting approvals for services

Sometimes we will pay for care only if we have given an approval before you get it. We call that "precertification." Precertification is usually limited to more serious care like surgery or being admitted to a hospital or skilled nursing facility. Your plan documents list all the services that require precertification. You are responsible for contacting the plan for precertification. If you don't, you will have to pay for all or a larger share of the cost of the service.

Call the number shown on your Aetna ID card to begin the process. You must get the approval before you receive the care.

Precertification is not required for emergency services.

What we look for when reviewing a precertification request
First, we check to see that you are still a member. And we make sure the service is considered medically necessary for your condition. We also check that the service and place requested to perform the service is cost effective. If we know of a treatment or place of service that is just as effective but costs less, we may talk to you or your doctor about it. We also look to see if you qualify for one of our case management programs. If so, one of our nurses may call to tell you about it and help you understand your upcoming procedure.

Precertification does not, however, verify if you have reached any plan dollar limits or visit maximums for the service requested. That means precertification is not a guarantee that the service will be covered.

Filing claims

To file a claim, you can download and print a claim form at **www.aetna.com/individuals-families-health-insurance/document-library/find-document-form.html**. You can also call Member Services at the number on your ID card to ask for a form. The claim form includes complete instructions including what documentation to send with it.

We determine how and whether a claim is paid based on the terms and conditions of the health coverage plan and our internal coverage policies. See section "Knowing what is covered" on page 6 to learn more about coverage policies.

Information about specific benefits

Aetna does not provide care or guarantee access to health services.

Emergency and urgent care and care after office hours

An emergency medical condition means your symptoms are sudden and severe. If you don't get help right away, an average person with average medical knowledge will expect that you could die or risk your health. For a pregnant woman, that includes her unborn child.

Emergency care is covered anytime, anywhere in the world. If you need emergency care, call 911 or go to the nearest emergency room. Emergency care services do not require precertification.

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

After-hours care – available 24/7
Call your doctor anytime if you have medical questions or concerns. Your doctor should have an answering service if you call after the office closes. You can also go to an urgent care center, which may have limited hours. To find a center near you, log on to **www.aetna.com** and search our list of doctors and other health care providers. Check your plan documents to see how much you must pay for urgent care services.

How we cover emergency care
When you receive emergency care from a doctor or hospital, you pay your cost share according to your plan. If your doctor bills you for more you may not have to pay it. Send the bill to the address listed on your member ID card. We will resolve any payment dispute with the provider.

Prescription drug benefit

Some plans encourage generic drugs over brand-name drugs
A generic drug is the same as a brand-name drug in dose, use and form. They are FDA approved and safe to use.

Generic drugs usually sell for less; so many plans give you incentives to use generics. That doesn't mean you can't use a brand-name drug, but you'll pay more for them. You'll not only pay your normal share of the cost, you'll also pay the difference in the two prices.

We may also encourage you to use certain drugs
Some plans encourage you to buy certain prescription drugs over others. The plan may even pay a larger share for those drugs. We list those drugs in the Aetna Preferred Drug Guide (also known as a "drug formulary"). This list shows which prescription drugs are covered on a preferred basis. It also explains how we choose medications to be on the list.

When you get a drug that is not on the preferred drug list, you usually will pay more. Check your plan documents to see how much you will pay. If your plan has an "open formulary," that means you can use those drugs, but you'll pay the highest copay under the plan. If your plan has a "closed formulary," those drugs are not covered.

Drug Manufacturer Rebates
Drug manufacturers may give us rebates when our members buy certain drugs. We may share those rebates with your employer. While those rebates for the most part apply to drugs on the Preferred Drug List, they may also apply to drugs not on the Preferred Drug List. But, in any case, in plans where you pay a percent of the cost, your share of the cost is based on the price of the drug before any rebate is received by Aetna.

In plans where you pay a percent of the cost instead of a flat dollar amount, you may pay more for a drug on the Preferred Drug List than for a drug not on the list.

Mail-order and specialty-drug services are from Aetna-owned pharmacies
Aetna Rx Home Delivery and Aetna Specialty Pharmacy are pharmacies that Aetna owns. These pharmacies are for-profit entities.

You might not have to stick to the list
If it is medically necessary for you to use a drug that's not on your plan's preferred drug list, you or your doctor (or pharmacist in the case of antibiotics and pain medicines) can ask us to make an exception. Check your plan documents for details.

You may have to try one drug before you can try another
Step therapy means you have to try one or more "prerequisite" drugs before a "step-therapy" drug will be covered. The preferred drug list includes step-therapy drugs. Your doctor might want you to skip one of these drugs for medical reasons. If so, you or your doctor (or pharmacist in the case of antibiotics and pain medicines) can ask for a medical exception.

Some drugs are not covered at all
Prescription drug plans do not cover drugs that don't need a prescription. Your plan documents might also list specific drugs that are not covered. You cannot get a medical exception for these drugs.

New drugs may not be covered
Your plan may not cover drugs that we haven't reviewed yet. You or your doctor may have to get our approval to use one of these new drugs.

Get a copy of the preferred drug list
The Aetna Preferred Drug Guide is posted to our website at www.aetna.com/formulary/. If you don't use the Internet, you can ask for a printed copy. Just call Member Services at the toll-free number on your Aetna ID card. We are constantly adding new drugs to the list. Look online or call Member Services for the latest updates.

Have questions? Get answers!
Ask your doctor about specific medications. Call Member Services (at the number on your ID card) to ask about how your plan pays for them. Your plan documents also spell out what's covered and what is not.

Behavioral health and substance abuse benefits

Here's how to get behavioral health services

- Emergency services – call 911.
- Call any licensed behavioral health specialist directly.
- If you're using your employer's or school's EAP program, the EAP professional can help you find a behavioral health specialist.

You can access most outpatient therapy services without precertification. However, you should first consult Member Services to confirm that any such outpatient therapy services do not require precertification.

Aetna Behavioral Health offers two prevention programs for our members:

- **Beginning Right® Depression Program:** Perinatal Depression Education, Screening and Treatment Referral and
- **SASDA:** Identification and Referral of Substance Abuse Screening for Adolescents with Depression and/or Anxiety Prevention

For more information on either of these prevention programs and how to enroll in the programs, ask Member Services for the phone number of your local Care Management Center.

Breast reconstruction benefits

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

(1) all stages of reconstruction of the breast on which a mastectomy has been performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;

(3) prostheses; and

(4) treatment of physical complications of all stages of mastectomy, including lymph edemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

For more information, you can visit this U.S. Department of Health and Human Services website, **www.cms.hhs.gov/HealthInsReformforConsume/06_TheWomen'sHealthandCancerRightsAct.asp** and the U.S. Department of Labor at: **www.dol.gov/ebsa/consumer_info_health.html**.

Oklahoma Breast Cancer Patient Protection Act

The Oklahoma Breast Cancer Patient Protection Act requires Aetna health plans to provide the following benefits:

- A member receiving benefits for a medically necessary mastectomy will be provided coverage for not less than 48 hours of inpatient care following the mastectomy, unless the attending physician in consultation with the member determines that a shorter period of hospital stay is appropriate.
- A member receiving benefits for a lymph node dissection for the treatment of breast cancer will be provided coverage for not less than 24 hours of inpatient care following the lymph node dissection, unless the attending physician in consultation with the member determines that a shorter hospital stay is appropriate.
- A member receiving benefits for a medically necessary partial or total mastectomy will be provided coverage for reconstructive breast surgery performed as a result of the mastectomy, except as prohibited by federal laws or regulations pertaining to Medicaid. When such reconstructive surgery is performed on a diseased breast, coverage will be provided for all stages of reconstructive surgery performed on a nondiseased breast to establish symmetry with the diseased breast, provided that the reconstructive surgery and any adjustments made to the nondiseased breast must occur within 24 months of reconstruction of the diseased breast.

Transplants and other complex conditions

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

Colorado mandated benefits

In Colorado, small group plans (groups with less than 50 members) must cover health services required by the state, including: coverages for newborn, maternity, pregnancy, childbirth, complications from pregnancy and childbirth, therapies for congenital defects and birth abnormalities, low-dose mammography, mental illness, biologically-based mental illness, the availability of alcoholism treatment, the availability of hospice care, prostate cancer screening, child health supervision, hospitalization and general anesthesia for dental procedures for dependent children, diabetes, prosthetic devices, early intervention services for certain children, colorectal screening, cervical cancer vaccinations and certain routine care during participation in a clinical trial.

Religious exemption for members in Connecticut

As permitted under Connecticut law, an insurer may issue to a religious employer a policy that excludes coverage for infertility treatment that is contrary to the religious employer's beliefs.

Some of these treatments may include:

- Ovulation induction (OI)
- Intrauterine insemination
- In-vitro fertilization (IVF)
- Embryo transfer
- Gamete intra-fallopian transfer (GIFT)
- Zygote intra-fallopian transfer (ZIFT)
- Low tubal ovum transfer
- Uterine embryo lavage

Religious exemption for members in West Virginia
West Virginia Legislation mandates that group insurance policies and contracts that provide coverage for prescription drugs must include a rider providing coverage for contraceptive drugs and devices that are approved by the FDA or generics approved as substitutes by the FDA. However, "religious employers," as defined in the law, may elect not to include this coverage under their policy or contract. If a Religious Employer elects not to provide coverage for contraceptives, each member/enrollee covered under the contract is eligible to obtain a contraceptive rider directly from Aetna. Please refer to your plan administrator for specifics regarding your benefits.

Knowing what is covered

You can avoid receiving an unexpected bill with a simple call to Member Services. You can find out if your preventive care service, diagnostic test or other treatment is a covered benefit — before you receive care — just by calling the toll-free number on your ID card.

Here are some of the ways we determine what is covered:

We check if it's "medically necessary"

Medical necessity is more than being ordered by a doctor. "Medically necessary" means your doctor ordered a product or service for an important medical reason. It might be to help prevent a disease or condition. Or to check if you have one. Or it might be to treat an injury or illness.

The product or service:

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

Only medical professionals can deny coverage if the reason is medical necessity. We do not give financial incentives or otherwise to Aetna employees for denying coverage.

Sometimes the review of medical necessity is handled by a physicians' group. Those groups might use different resources than we do.

If we deny coverage, we'll send you and your doctor a letter. The letter will explain how to appeal the denial. You have the same right to appeal if a physician's group denied coverage for medical necessity. You can call Member Services to ask for a free copy of the criteria we use to make coverage decisions. Or visit **www.aetna.com/about/cov_det_policies.html** to read our policies. Doctors can write or call our Patient Management department with questions. Contact Member Services either online or at the phone number on your Aetna ID card for the appropriate address and phone number.

We study the latest medical technology

To help us decide what is medically necessary, we may look at scientific evidence published in medical journals. This is the same information doctors use. We also make sure the product or service is in line with how doctors, who usually treat the illness or injury, use it. Our doctors may use nationally recognized resources like The Milliman Care Guidelines.

We also review the latest medical technology, including drugs, equipment — even mental health treatments. Plus, we look at new ways to use old technologies. To make decisions, we may:

- Read medical journals to see the research. We want to know how safe and effective it is.
- See what other medical and government groups say about it. That includes the federal Agency for Health Care Research and Quality.
- Ask experts.
- Check how often and how successfully it has been used.

We publish our decisions in our Clinical Policy Bulletins.

We post our findings on www.aetna.com

After we decide if a product or service is medically necessary, we write a report about it. We call the report a Clinical Policy Bulletin (CPB).

CPBs tell if we view a product or service as medically necessary. They also help us decide whether to approve a coverage request. But your plan may not cover everything that our CPBs say is medically necessary. Each plan is different, so check your plan documents.

CPBs are not meant to advise you or your doctor on your care. Only your doctor can give you advice and treatment. Talk to your doctor about any CPB related to your coverage or condition.

You and your doctor can read our CPBs on our website at **www.aetna.com** under "Individuals & Families." No Internet? Call Member Services at the toll-free number on your ID card. Ask for a copy of a CPB for any particular product or service.

We can help when more serious care is suitable

In certain cases, we review a request for coverage to be sure the service or supply is consistent with established guidelines. Then we follow up. We call this "utilization management review."

It's a three step process:

First, we begin this process if your hospital stay lasts longer than what was approved. We verify that it is necessary for you to still be in the hospital. We look at the level and quality of care you are getting. (In **South Dakota**, "concurrent review" is defined as a utilization review conducted during a patient's hospital stay or course of treatment in a facility or other inpatient or outpatient health care setting.)

Second, we begin planning your discharge. This process can begin at any time. We look to see if you may benefit from any of our programs. We might have a nurse case manager follow your progress. Or we might recommend that you try a wellness program after you get back home.

Third, after you are home, we may review your case. We may look over your medical records and claims from your doctors and the hospital. We look to see that you got appropriate care. We also look for waste or unnecessary costs.

We follow specific rules to help us make your health a top concern:

- Aetna employees are not compensated based on denials of coverage.
- We do not encourage denials of coverage. In fact, our utilization review staff is trained to focus on the risks of members not adequately using certain services.

Where such use is appropriate, our Utilization Review/Patient Management staff uses nationally recognized guidelines and resources, such as The Milliman Care Guidelines® to guide these processes. When provider groups, such as independent practice associations, are responsible for these steps, they may use other criteria that they deem appropriate.

What to do if you disagree with us

Complaints, appeals and external review

Please tell us if you are not satisfied with a response you received from us or with how we do business.

Call Member Services to file a verbal complaint or to ask for the appropriate address to mail a written complaint. The phone number is on your Aetna ID card. You can also e-mail Member Services through the secure member website.

If you're not satisfied after talking to a Member Services representative, you can ask that your issue be sent to the appropriate department.

If you don't agree with a denied claim, you can file an appeal. To file an appeal, follow the directions in the letter or explanation of benefits statement that explains that your claim was denied. The letter also tells you what we need from you and how soon we will respond.

Get a review from someone outside Aetna
In some cases, you can ask for an outside review if you're not satisfied after going through our internal appeals process. Follow the instructions on our response to your appeal. Call Member Services to ask for an External Review Form or log on to **www.aetna.com/individuals-families-health-insurance/member-guidelines/ext_review.html**.

Most claims are allowed to go to external review. An exception would be if you are denied because you're no longer eligible for the plan.

If your case qualifies, an Independent Review Organization (IRO) will assign it to an outside expert. The expert will be a doctor or other professional who specializes in that area or type of dispute. You should have a decision within 45 calendar days of the request.

We will follow the external reviewer's decision. We will also pay the cost of the review.

A "rush" review may be possible
If your doctor thinks you cannot wait 45 days, ask for an "expedited review." That means we will make our decision more quickly.

Member rights & responsibilities

Know your rights as a member

You have many legal rights as a member of a health plan. You also have many responsibilities. You have the right to suggest changes in our policies and procedures, including our Member Rights and Responsibilities.

Below are just some of your rights. We also publish a list of rights and responsibilities on our website. Visit **www.aetna.com/individuals-families-health-insurance/member-guidelines/member-rights.html** to view the list. You can also call Member Services at the number on your ID card to ask for a printed copy.

Making medical decisions before your procedure

An "advanced directive" tells your family and doctors what to do when you can't tell them yourself. You don't need an advanced directive to receive care. But you have the right to create one. Hospitals may ask if you have an advanced directive when you are admitted.

There are three types of advanced directives:

- Durable power of attorney – name the person you want to make medical decisions for you.
- Living will – spells out the type and extent of care you want to receive.
- Do-not-resuscitate order – states that you don't want CPR if your heart stops or a breathing tube if you stop breathing.

You can create an advanced directive in several ways:

- Ask your doctor for an advanced directive form.
- Pick up a form at state or local offices on aging, bar associations, legal service programs or your local health department.
- Work with a lawyer to write an advanced directive.
- Create an advanced directive using computer software designed for this purpose.

Source: American Academy of Family Physicians. *Advanced Directives and Do Not Resuscitate Orders*. September 2010. Available at **http://familydoctor.org/online/famdocen/home/pat-advocacy/endoflife/003.html**. Accessed December 6, 2010.

Learn about our quality management programs

We make sure your doctor provides quality care for you and your family. To learn more about these programs, go to our website at **www.aetna.com/individuals-families-health-insurance/member-guidelines/health-care-quality.html**. You can also call Member Services to ask for a printed copy. See "Contact Us" on page 1.

We protect your privacy

We consider your personal information to be private. Our policies help us protect your privacy. By "personal information," we mean information about your physical condition, the health care you receive and what your health care costs. Personal information does not include what is available to the public. For example, anyone can find out what your health plan covers or how it works. It also does not include summarized reports that do not identify you.

Below is a summary of our privacy policy. For a copy of our actual policy, go to **www.aetna.com**. You'll find the "Privacy Notices" link at the bottom of the page. You can also write to:
Aetna Legal Support Services Department
151 Farmington Avenue, W121
Hartford, CT 06156

Summary of the Aetna privacy policy
We have policies and procedures in place to protect your personal information from unlawful use and disclosure. We may share your information to help with your care or treatment and administer our health plans and programs. We use your information internally, share it with our affiliates, and we may disclose it to:

- Your doctors, dentists, pharmacies, hospitals and other caregivers
- Those who pay for your health care services. That can include health care provider organizations and employers who fund their own health plans or who share the costs.
- Other insurers
- Third-party administrators
- Vendors
- Consultants
- Government authorities and their respective agents

These parties must also keep your information private. Doctors in the Aetna network must allow you to see your medical records within a reasonable time after you ask for them.

Some of the ways we use your personal information include:

- Paying claims
- Making decisions about what to cover
- Coordinating payments with other insurers
- Preventive health, early detection, and disease and case management

We consider these activities key for the operation of our health plans. We usually will not ask if it's okay to share your information unless the law requires us to. We will ask your permission to disclose personal information if it is for marketing purposes. Our policies include how to handle requests for your information if you are unable to give consent.

Anyone can get health care

We do not consider your race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national origin when giving you access to care. Network providers are contractually obligated to the same.

We must comply with these laws:

- Title VI of the Civil Rights Act of 1964
- Age Discrimination Act of 1975
- Americans with Disabilities Act
- Laws that apply to those who receive federal funds
- All other laws that protect your rights to receive health care

How we use information about your race, ethnicity and the language you speak

You choose if you want to tell us your race/ethnicity and preferred language. We'll keep that information private. We use it to help us improve your access to health care. We also use it to help serve you better. See "We protect

your privacy" to learn more about how we use and protect your private information. See also "Anyone can get health care."

Your rights to enroll later if you decide not to enroll now

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

When you have a new dependent
Getting married? Having a baby? A new dependent changes everything. And you can change your mind. If you chose not to enroll during the normal open enrollment period, you can enroll within 31 days after a life event. That includes marriage, birth, adoption or placement for adoption. Talk to your benefits administrator for more information, to request special enrollment or for more information.

Getting proof that you had previous coverage
Sometimes when you apply for health coverage, the insurer may ask for proof that you were covered before. This helps determine if you are eligible for their plan. Your plan sponsor may have contracted with us to issue a certificate. Ask us for a Certificate of Prior Health Coverage anytime you want to check the status of your coverage. If you lost your coverage, you have 24 months to make this request. Just call Member Services at the toll-free number on your ID card.

Other rights by state

Colorado
Small employers purchasing any health benefit plan other than the Colorado Basic Limited Mandate Health Benefit Plan must pay for all of the mandated benefits pursuant to section 10-16-104, C.R.S. The premium for this plan includes the cost of these mandated benefits, specifically: coverages for newborn, maternity, pregnancy, childbirth, complications from pregnancy and childbirth, therapies for congenital defects and birth abnormalities, low-dose mammography, mental illness, biologically-based mental illness, the availability of alcoholism treatment, the availability of hospice care, prostate cancer screening, child health supervision, hospitalization and general anesthesia for dental procedures for dependent children, diabetes, prosthetic devices, early intervention services for certain children, colorectal screening, cervical cancer vaccinations, and certain routine care during participation in a clinical trial.

Hawaii – Informed Consent
You have the right to be fully informed before making any decision about any treatment, benefit, or nontreatment. Your doctor or health care provider will:

- Discuss all treatment options, including the option of no treatment at all
- Ensure that persons with disabilities have an effective means of communication with the provider and other members of the managed care plan
- Discuss all risks, benefits, and consequences of treatment and nontreatment

Your provider will also discuss with you and your immediate family both living wills and durable powers of attorney in relation to medical treatment.

Hawaii State Insurance Department
You may contact the Hawaii Insurance Division and the Office of Consumer Complaints at **1-808-586-2790**.

Illinois
Illinois law requires health plans to provide the following information each year to enrollees and to prospective enrollees upon request:

- A description of the following terms of coverage:
  1. The service area
  2. The covered benefits and services with all exclusions, exceptions and limitations
  3. The precertification and other utilization review procedures and requirements
  4. The emergency coverage and benefits, including any restrictions on emergency care services
  5. The out-of-area coverage and benefits, if any
  6. The enrollee's financial responsibility for copayments, deductibles, premiums, and any other out-of-pocket expenses
  7. The appeals process, forms, and time frames for health care services appeals, complaints, and external independent reviews, administrative complaints, and utilization review complaints, including a phone number to call to receive more information from the health care plan concerning the appeals process
  8. A statement of all basic health care services and all specific benefits and services to be provided to enrollees by a state law or administrative rule

Kansas
Kansas law permits you to have the following information upon request:

1. A complete description of the health care services, items and other benefits to which the insured is entitled in the particular health plan that is covering or being offered to such person

2. A description of any limitations, exceptions or exclusions to coverage in the health benefit plan, including prior authorization policies, restricted drug formularies or other provisions that restrict access to covered services or items by the insured
3. Notification in advance of any changes in the health benefit plan that either reduces the coverage or benefits or increases the cost to such person
4. A description of the grievance and appeal procedures available under the health benefit plan and an insured's rights regarding termination, disenrollment, nonrenewal or cancellation of coverage

If you are a member, contact Member Services by calling the toll-free number on your ID card to ask for more information. If you are not yet an Aetna member, contact your plan administrator.

Louisiana – Genetic Testing
Aetna will not in any way use the results of genetic testing to discriminate against applicants or enrollees.

North Carolina
Procedures and medically based criteria for determining whether a specified procedure, test or treatment is experimental are available upon request.

Notes

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