Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

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Important Disclosure Information

Aetna Health Maintenance Organization (HMO)
Elect Choice®
Aetna Select®

www.aetna.com

01.28.334.1 (6/15)

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. This is a "self-funded plan," which means your employer, and not Aetna, is responsible for the design of the plan and what benefits are covered under it. The plan covers recommended preventive care and care 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 some services may have limits. For example, a plan may allow only one eye exam per year.

Where to find information about 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. Your "plan documents" list all the details for the plan you chose. This includes what's covered, what's not covered and what you will pay for services. Plan document names vary. They may include a Schedule of Benefits, Summary Plan Description (SPD), and Summary of Material Modification (SMM) and/or any updates that come with them.

If you can't find your plan documents, call your employer to ask for a copy. Your employer, and not Aetna, is responsible for providing copies of plan documents like SPDs and SMMs to plan participants.

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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 plans are offered by your employer with administrative services only provided by Aetna Life Insurance Company. In California, fully insured Elect Choice EPO health insurance plans are underwritten by Aetna Life Insurance Company.

Get plan information online and by phone

If you're already enrolled in an Aetna health plan

You have three convenient ways to get plan information anytime, day or night:

1. **Log in to your secure Aetna Navigator® member website**

   You can get coverage information for your plan online. You can also get details about any programs, tools and other services that come with your plan. Just register once to create a user name and password.

   Have your Aetna ID card handy to register. Then visit **www.aetna.com** and click "Log In/Register." Follow the prompts to complete the one-time registration.

   Then you can log in any time to:

   - Verify who's covered and what's covered
   - Track claims or view past copies of explanation of benefits statements
   - Use the DocFind® search tool to find in-network care
   - Use our cost-of-care tools so you can *know before you go*
   - Learn more about and access any wellness programs that come with your plan

2. **Use your mobile device to access a streamlined version of Aetna Navigator**

   Go to your Play Store (Android) or App Store (iPhone) and search for Aetna Mobile. You can also text **APPS** to **23862** to download.

   Here's just some of what you can do from Aetna Mobile:

   - Find a doctor or facility
   - View alerts and messages
   - View your claims, coverage and benefits
   - View your ID card information
   - Use the Member Payment Estimator
   - Contact us by phone or e-mail

3. **Call Member Services at the toll-free number on your Aetna ID card**

   As an Aetna member you can use the Aetna Voice Advantage self-service options:

   - Verify who's covered under your plan
   - Find out what's covered under your plan
   - Get an address to mail your claim and check a claim status
   - Find other ways to contact Aetna
   - Order a replacement Aetna ID card
   - Be transferred to mental health services (if included in your plan)

   You can also speak with a representative to:

   - Understand how your plan works or what you will pay
   - Get information about how to file a claim
   - Get a referral
   - Find care outside your area
   - File a complaint or appeal
   - Connect to mental health services (if included in your plan)
   - Find specific health information
   - Learn more about our Quality Management program

Not yet a member?

For help understanding how a particular medical plan works, you should review your Summary of Benefits and Coverage document or contact your employer or benefits administrator.

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

Use our DocFind search tool for the most up-to-date list of health care professionals and facilities. You can get a list of available doctors by Zip code, or enter a specific doctor's name in the search field.

Existing members: Visit **www.aetna.com** and log in. From your secure member website home page, select "Find a Doctor" from the top menu bar and start your search.

Considering enrollment: Visit **www.aetna.com** and scroll down to "Find a doctor, dentist, facility or vision provider" from the home page. You'll need to select the plan you're interested in from the drop-down box.

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

- Where the physician attended medical school
- Board certification status
- Language spoken
- Hospital affiliations
- Gender
- Driving directions

Get a FREE printed directory

To get a free printed list of doctors and hospitals, call the toll-free number on your Aetna ID card. If you're not yet a member, call **1-888-982-3862**.

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

If you require language assistance, please call the Member Services number on your Aetna ID card, and an Aetna representative will connect you with an interpreter. You can also get interpretation assistance for utilization management issues or for registering a complaint or appeal. If you're deaf or hard of hearing, use your TTY and dial 711 for the Telecommunications Relay Service. Once connected, please enter or provide the Aetna telephone number you're calling.

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

Si usted necesita asistencia lingüística, por favor llame al número de Servicios al Miembro que figura en su tarjeta de identificación de Aetna, y un representante de Aetna le conectará con un intérprete. También puede recibir asistencia de interpretación para asuntos de administración de la utilización o para registrar una queja o apelación. Si usted es sordo o tiene problemas de audición, use su TTY y marcar 711 para el Servicio de Retransmisión de Telecomunicaciones (TRS). Una vez conectado, por favor entrar o proporcionar el número de teléfono de Aetna que está llamando.

Accountable Care Organizations (ACOs) — Physician networks that help to improve care while lowering costs
Accountable care organizations are networks of primary care doctors, specialists and at least one hospital. Their mission is to better coordinate patient care to improve efficiency, quality and patient satisfaction.

Like most plans, Aetna pays these doctors and hospitals on a fee-for-service basis. They are paid more when they meet certain goals. The amount of these payments depends on how well the ACOs meet goals* for efficiency and quality:

- Increase screenings for cancer, diabetes and cholesterol
- Reduce avoidable ER visits, short-term hospital stays, repetitive tests and the overall cost of care

The ACO may also have to make payments to your employer if they fail to meet their goals. This helps encourage savings that are tied to value and better health outcomes for our members. Doctors and hospitals that are members of an ACO may have their own financial arrangements through the network itself. Ask your doctor for details.

It's important for doctors to see a complete view of your health care to provide customized treatment plans for your unique needs. For that reason, Aetna may share your health information with the accountable care organization and/or doctors within the network.

You can see which health care providers are part of an ACO when you use our DocFind® search tool. See "Search our network for doctors, hospitals and other health care providers" in this booklet for details. After entering your search criteria, look for the specific network logo.

*The specific goals will vary from network to network.

What you pay

Under most self-funded plans, 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 set amount (for example, $25) you pay for a covered health care service. You usually pay this when you get the service. The amount can vary by the type of service. For example, you may pay a different amount to see a specialist than you would pay to see your family doctor.

  Other copays may apply at the same time:
  - **Inpatient Hospital Copay –** This copay applies when you are a patient in a hospital.
  - **Emergency Room Copay –** 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.
- **Coinsurance –** Your share of the costs for a covered service. This is usually a percentage (for example, 20 percent) 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 percent would be $20. The health plan pays the rest of the allowed amount.
- **Deductible –** The amount you owe for health care services before your health plan begins to pay. For example, if your deductible is $1,000, you have to pay the first $1,000 for covered services before the plan begins to pay. You may not have to pay the deductible for some services.

These are generic terms and definitions. Check your specific plan's SPD for the definitions used in you plan.

Your costs when you go outside the network

HMO, Elect Choice and Aetna Select are network-only plans. That means the plan covers health care services only when provided by a doctor who participates in the Aetna network. If you receive services from an out-of-network doctor or other health care provider, you will have to pay all of the costs for the services, with the exception of care provided in an emergency. See "Emergency and urgent care and care after office hours" for more.

Going in network just makes sense.
- The plan includes negotiated discounted rates.
- In-network doctors and hospitals won't bill you for costs above the plan's rates for covered services.
- You get access to quality care from our national network.

To learn more about how your plan pays out-of-network benefits, visit **www.aetna.com**. Type "how Aetna pays" in the search box.

PCPs, referrals and other rules for using your plan

Choose a primary care physician

You must choose any primary care provider who participates in the Aetna network and who is accepting new patients. If you do not pick a PCP when required, your benefits may be limited or Aetna may select a PCP for you. Even if not required, it is still a good idea to choose a PCP. That's because a PCP can get to know your health care needs and help you better manage your health care.

A PCP is the doctor you go to when you need health care. If it's an emergency, you don't have to call your PCP first. This one doctor can coordinate all your care for non-emergency situations. Your PCP will perform physical exams, order tests and screenings and help you when you're sick. Your PCP will also refer you to a specialist when needed.

Tell us who you chose to be your PCP
Each member of the family may chose a different PCP from the Aetna network. Enter the name of the PCP you have chosen on your enrollment form. Or, call Member Services after you enroll to tell Aetna your selection. The name of your PCP will appear on your Aetna ID card. You may change your selected PCP at any time. If you change your PCP, you will receive a new ID card.

Referrals: Your PCP may refer you to a specialist when needed

A "referral" is a written request for you to see another doctor. Some doctors can send the referral right to your specialist for you. There's no paper involved.

Talk to your doctor to understand why you need to see a specialist. And remember to always get the referral before you receive the care.

Remember these points about referrals:

- You do not need a referral for emergency care.
- If you do not get a referral when required, you may have to pay the bill yourself. If your plan lets you go outside the network, the plan will pay it as an out-of-network benefit.
- Your specialist might recommend treatment or tests that were not on the original referral. In that case, you may need to get another referral from your PCP for those services.
- Women can go to an Ob/Gyn without a referral. See "PCP and referral rules for Ob/Gyns" below.
- Referrals are valid for one year as long as you are still a member of the plan. Your first visit must be within 90 days of the referral issue date.

Referrals within physician groups

Some PCPs are part of a larger group of doctors. These PCPs will usually refer you to another doctor within that same group. If this group cannot meet your medical needs, you can ask Aetna for a coverage exception to go outside this group. You may also need to precertify these services. And you may need permission from the physician group as well.

PCP and referral rules for obstetricians and gynecologists (Ob/Gyn)

A female member can go to any Ob/Gyn who participates in the Aetna network without a referral or prior authorization. Visits can be for:

- Checkups, including breast exam
- Mammogram
- Pap smear
- Obstetric or gynecologic problems

Also, an Ob/Gyn can give referrals for covered obstetric or gynecologic services just like a PCP. Just follow your plan's normal rules. Your Ob/Gyn might be part of a larger physician's group. If so, any referral will be to a specialist in that larger group. Check with the Ob/Gyn to see if the group has different referral policies.

Precertification: Getting approvals for services

Sometimes we will pay for care only if we have given an approval before you get it. We call that "precertification." You usually only need precertification for more serious care like surgery or being admitted to a hospital. Your plan documents list all the services that require this approval. Your PCP or network specialist will get this approval for you.

You do not have to get precertification for emergency services.

What we look for when reviewing a request

First, as your self-funded plan's claims administrator, 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 make sure the service and place requested to perform the service are cost effective. Our decisions are based entirely on appropriateness of care and service and the existence of coverage, using nationally recognized guidelines and resources. We may suggest a different treatment or place of service that is just as effective but costs less. We also look to see if you qualify for one of our case management programs. If so, one of our nurses may contact you.

Precertification does not verify if you have reached any plan dollar limits or visit maximums for the service requested. So, even if you get approval, the service may not be covered.

Review process after precertification (Utilization Review/ Patient Management)

The patient management program can help you access appropriate health care and maximize coverage for those health care services. In certain situations, your case is reviewed to be sure the service or supply meets established guidelines and is a covered benefit under your plan. This is called "utilization review."

The plan follows specific rules to help make your health a top concern during reviews

- The plan does not reward reviewers for denying coverage.
- The plan does not encourage denials of coverage. In fact, review staff focuses on the risks of members not getting proper care. Where such use is appropriate, reviewers use nationally recognized guidelines and resources, such as MCG (formerly Milliman Care Guidelines) to review requests for coverage. Physician groups, such as independent practice associations, may use other resources they deem appropriate.
- The plan does not encourage utilization decisions that result in underutilization.

Information about specific benefits

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 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, follow these guidelines:

- Call 911 or go to the nearest emergency room. If you have time, call your doctor or PCP.
- Tell your doctor or PCP as soon as possible afterward. A friend or family member may call on your behalf.
- You do not have to get approval for emergency services.

You are covered for emergency care
You have emergency coverage while you are traveling or if you are near your home. That includes students who are away at school.

Sometimes you don't have a choice about where you go for care, like if you go to the emergency room for a heart attack or a car accident. When you need care right away, go to any doctor, walk-in clinic, urgent care center or emergency room. When you have no choice, the plan will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance and deductibles for your in-network level of benefits.

The plan will review the information when the claim comes in. If the reviewer thinks the situation was not urgent, he or she might ask you for more information and may send you a form to fill out. Please complete the form, or call Member Services to provide the information over the phone.

Follow-up care
Your PCP should coordinate all follow-up care. For example, you'll need a doctor to remove stitches or a cast or take another set of X-rays to see if you've healed. You will need a referral for follow-up care that is not performed by your PCP. You may also need to get approval if you go outside the network.

After-hours care – available 24/7
Call your doctor when 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 in to **www.aetna.com** and search the plan's list of doctors and other health care providers. Check your plan documents to see how much you must pay for urgent care services.

Prescription drug benefit

Check your plan documents to see if your plan includes prescription drug benefits. The following information applies if your self-funded plan provides prescription drug coverage AND the claims for coverage are administered by Aetna.

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 it. You'll pay your normal share of the cost, and you'll also pay the difference in the two prices.

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

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

Drug companies may give the plan rebates when you buy certain drugs
The plan may share those rebates with your employer. Rebates usually apply to drugs on the preferred drug guide. They may also apply to drugs not in the guide. In plans where you pay a percentage of the cost, your share of the cost is based on the price of the drug before the plan receives any rebate. Sometimes, in plans where you pay a percentage of the cost instead of a flat dollar amount, you may pay more for a drug in the preferred drug guide than for a drug not in the guide.

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

You might not have to stick to the preferred drug guide
Sometimes your doctor might recommend a drug that's not in the preferred drug guide. If it is medically necessary for you to use that drug, you, someone helping you or your doctor can ask the plan to make an exception. Your pharmacist can also ask for an exception for antibiotics and pain medicines. Check your plan documents for details.

You may have to try one drug before you can try another
"Step-therapy" means you may have to try one or more less expensive or more common drugs before a drug on the step-therapy list will be covered. Your doctor might want you to skip one of these drugs for medical reasons. If so, you, someone helping you or your doctor can ask for a medical exception. Your pharmacist can also ask for an exception for antibiotics and pain medicines.

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 it hasn't reviewed yet. You, someone helping you or your doctor may have to get plan approval to use one of these new drugs.

Get a copy of the preferred drug guide
You can find the Aetna Preferred Drug Guide at **www.aetna.com/formulary/**. You can call the toll-free number on your Aetna ID card to ask for a printed copy. The plan occasionally adds new drugs to the guide. Look online or call Member Services for the latest updates.

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

Mental health and addiction benefits

The following information applies if your self-funded plan includes mental health services with claims administered by Aetna.

You must use therapists and other mental health professionals who are in the Aetna network. Here's how to get inpatient and outpatient services, partial hospitalization and other mental health services:

- Call 911 if it's an emergency.
- Call the toll-free Behavioral Health number on your Aetna ID card.
- Call Member Services if no other number is listed.
- Employee Assistance Program (EAP) professionals can also help you find a mental health specialist.

Get information about using network therapists
Visit **www.aetna.com/docfind** and click the "Quality and Cost Information" link. No Internet? Call Member Services instead. Use the toll-free number on your Aetna ID card to ask for a printed copy.

Aetna Behavioral Health offers two screening and prevention programs for members

- **Beginning Right® Depression Program:** Perinatal and Postpartum Depression Education, Screening and Treatment Referral
- **SASADA Program:** Substance Abuse Screening for Adolescents with Depression and/or Anxiety

Call Member Services to learn more about these programs.

Transplants and other complex conditions

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

Important benefits for women

Women's Health and Cancer Rights Act of 1998
Your plan provides benefits for mastectomy and mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between breasts; prosthesis; and treatment of physical complications of all stages of mastectomy, including lymphedema. Coverage is provided in accordance with your plan design and is subject to plan limitations, copays, deductibles, coinsurance and referral requirements, if any, as outlined in your plan documents.

Please contact Member Services for more information, or visit the U.S. Department of Health and Human Services website, **www.cms.gov/HealthInsReformforConsume/Downloads/WHCRA_Helpful_Tips_2010_06_14.pdf**, and the U.S. Department of Labor website, **www.dol.gov/ebsa/consumer_info_health.html**.

No coverage based on U.S. Sanctions

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

Knowing what is covered

Avoid unexpected bills. Check your plan documents to see what's covered before you get health care. Call Member Services to ask a specific question about what's covered. Can't find your plan documents? Call your employer to have a copy mailed to you.

Here are some of the ways your plan determines what is covered:

Plans only cover medically necessary products and services

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
- Must 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 — either within Aetna or in some cases, independent medical reviewers — can decide if a treatment or service is not medically necessary. The plan does not reward medical reviewers for denying coverage. Sometimes a physician's group will determine medical necessity. Those groups might use different resources than Aetna, and so Aetna's decision may differ from your doctor. If a claim for benefits is denied based upon our determination that the service was not medically necessary, you may be able to appeal that denial. See "What to do if you disagree with us" for information on how to complain or file an appeal of a denied claim.

If we deny coverage, you and your doctor will receive 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. You can call Member Services to ask for a free copy of the materials used to make coverage decisions. Or visit **www.aetna.com/about/cov_det_policies.html** to read Aetna coverage policies. Doctors can write or call the 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.

Aetna uses scientific evidence published in medical journals to help decide what is medically necessary
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. We may use nationally recognized resources like MCG (formerly Milliman Care Guidelines).

Aetna reviews the latest medical technology, including drugs, equipment and mental health treatments. Plans also look at new ways to use old technologies. To make decisions, we may:

- Review medical journal research to ensure the product or service is safe and effective.
- See what other medical and government groups say about it. That includes the federal Agency for Healthcare Research and Quality.
- Ask experts.
- Check how often and how successfully it has been used.

You can review Aetna Clinical Policy Bulletins on www.aetna.com

You can see published reports about whether products or services are generally eligible for coverage under plans with claims administered by Aetna and when the products or services are determined to be medically necessary. These reports are called Clinical Policy Bulletins (CPBs).

CPBs help the plan decide whether to approve a specific member coverage request. Your plan may not cover everything the 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 the CPBs at **www.aetna.com**. You can find them under "Individuals & Families." No Internet? Call Member Services at the toll-free number on your Aetna ID card. Ask for a copy of a CPB for any product or service.

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 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 a representative to send your issue to the appropriate complaint 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 says your claim was denied. The letter also tells you what we need from you and how soon you'll receive a response.

Also refer to your plan documents for: specific information on how to appeal a denied claim; when that appeal can be expedited; a description of the different kinds of appeals and their deadlines for filing appeals; and, whether Aetna, your employer or their delegate makes the decision on your appeal. You may have the right to appeal more than once under your specific plan.

Get a review from someone outside Aetna
If the denial is based on a medical judgment, you may be able to get an outside review if you're not satisfied with your appeal. Follow the instructions on the response to your appeal. Call Member Services to ask for an external review form. You can also visit **www.aetna.com**. Enter "external review" into the search bar.

If the reason for your denial is that you are no longer eligible for the plan, or you have appealed after the deadline for doing so under your plan has passed, you may not be able to get an outside review.

An independent review organization (IRO) will assign your case to an outside expert. The expert will be a doctor or other professional who specializes in that area or type of appeal. You should have a decision within 45 calendar days of the request. The outside reviewer's decision is final and binding; we will follow the outside reviewer's decision. We will also pay the cost of the review.

A "rush" review may be possible
If your doctor thinks you cannot wait 45 days, ask for an "expedited review." That means the IRO will make its decision as soon as possible.

Member rights and 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 Aetna policies and procedures. This includes our member rights and responsibilities.

Some of your rights are below. The plan administrator also publishes a list of rights and responsibilities at **www.aetna.com/individuals-families/member-rights-resources.html**. 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 "advance directive" tells your family and doctors what to do when you can't tell them yourself. You don't need an advance directive to receive care, but you have the right to create one. Hospitals may ask if you have an advance directive when you are admitted.

There are three types of advance 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 you don't want cardiopulmonary resuscitation (CPR) if your heart stops or a breathing tube if you stop breathing.

You can create an advance directive in several ways:

- Ask your doctor for an advance directive form.
- Write your wishes down by yourself.
- Pick up a form at state or local offices on aging, or your local health department.
- Work with a lawyer to write an advance directive.
- Create an advance directive using computer software designed for this purpose.

Source: American Academy of Family Physicians. Advanced Directives and Do Not Resuscitate Orders. January 2012. Available at **http://familydoctor.org/familydoctor/en/healthcare-management/end-of-life-issues/advance-directives-and-do-not-resuscitate-orders.html**. Accessed January 12, 2015.

Your personal information is private

Aetna policies protect your personal information from unlawful use. "Personal information," means information that can identify you as a person, as well as your financial and health information.

Personal information does not include what is available to the public. For example, anyone can access information about what the plan covers. It also does not include reports that do not identify you.

Summary of the Aetna Privacy Policy
When necessary for your care or treatment, the operation of health plans or other related activities, Aetna uses your personal information, or may share it with affiliates and may disclose it to:

- Your doctors, dentists, pharmacies, hospitals and other caregivers
- Other insurers
- Vendors
- Government departments
- Third-party administrators (TPAs) (this includes plan sponsors and/or employers)

These parties are required to keep your information private as required by law.

Some of the ways in which Aetna may use your information include:

- Administering claims
- Making decisions about what the plan covers
- Coordination of payments with other insurers
- Quality assessment
- Activities to improve the plans
- Audits

These activities are key for the operation of your plan. When allowed by law, we use and disclose your personal information in the ways explained above without your permission. The privacy notice includes a complete explanation of the ways your information is used and disclosed. It also explains when the plan will need your permission to use or disclose your information.

The plan is required to give you access to your information. If you think there is something wrong or missing in your personal information, you can ask that it be changed. The plan must complete your request within a reasonable amount of time. If we don't agree with the change, you can file an appeal.

For more information about our privacy notice or if you'd like a copy, call the toll-free number on your Aetna ID card or visit us at **www.aetna.com**.

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 legally required to the same.

Your plan 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 your plan uses 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. Your plan uses it to help improve your access to health care. We also use it to help serve you better. See "Your personal information is private" to learn more about how the plan uses and protects 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 you or your family experiences certain other life events such as divorce, or the death of the family member employed by the plan's sponsor, 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). Contact Member Services, your employer's Human Resources Department, or check your SPD for more information.

When you have a new dependent

Getting married? Having a baby? A new dependent changes everything. And you can change your mind. You can enroll within 31 days after a life event if you chose not to enroll during the normal open enrollment period. Life events include:

- Marriage
- Birth
- Adoption
- Placement for adoption

Talk to your benefits administrator for more information or to request special enrollment.

Rhode Island All Payer Claims Database (APCD)

The Rhode Island All Payer Claims Database (APCD) provides reports about health care quality, cost and reforms. Policy makers will use it to help them make better decisions regarding health care quality.

All health insurers in Rhode Island will send information to the APCD. To maintain your privacy, we will not send any of the following to the database:

- Your name
- Address
- Social Security number
- Telephone number
- E-mail address
- Any other information that could identify you

All information collected is anonymous and security is very tight.

It's your right to opt out of the project
If you want to have your information excluded, please go to **www.riapcd-optout.com** and provide a few facts about yourself. This will ensure we exclude your information correctly. If you don't have access to the Internet and would like to opt out, please call Rhode Island's Health Insurance Consumer Support toll-free at **1-855-747-3224**.

Questions?
Please contact the Rhode Island All Payer Claims Database at **OHIC.RIAPCD@ohic.ri.gov** or call Rhode Island's Health Insurance Consumer Support toll-free at **1-855-747-3224** if you have any questions.

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

As a participant in an employer-funded group health plan, you are entitled to certain rights and protections under ERISA. Some of those rights are listed below. Your rights are outlined in more detail in your plan documents as described in the beginning of this booklet. See "Understanding your plan of benefits" and "Where to find information about your specific plan." You have the right to:

- Receive, free of charge, information about your plan and benefits.
- Upon written request to your plan administrator, examine copies of documents governing the operation of the plan, contracts, collective bargaining agreements, annual reports and more. The administrator may charge you a reasonable copy fee.
- Receive a copy of procedures used to determine a qualified domestic relation or medical child support order.
- Continue group health coverage for you, your spouse or dependents if there is a loss of coverage as the result of a qualifying event.
- Know why a claim was denied.
- Exercise your rights, and take steps to enforce your rights, without discrimination or retribution.
- Get answers to your questions about the plan. See "Get plan information online and by phone" in this booklet for details.

Contact your plan administrator with questions about your plan. If they do not provide the information you request, you can get help from the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory. You may also write to:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

Aetna is committed to Accreditation by the National Committee for Quality Assurance (NCQA) as a means of demonstrating a commitment to continuous quality improvement and meeting customer expectations. A complete list of health plans and their NCQA status can be found on the NCQA website located at **http://reportcard.ncqa.org**.

To refine your search, we suggest you search these areas:

1. **Health Insurance Plans** – for HMO and PPO health plans and
2. **Physicians and Physician Practices** – for physicians recognized by NCQA in the areas of Physician Practice Connections, Physician Practice Connections-Patient Centered Medical Home, Patient Centered Medical Home, Heart/Stroke, Diabetes, and Patient Center Specialty Practice. Providers, in all settings, achieve recognition by submitting data that demonstrate they are providing quality care. The program constantly assesses key measures that were carefully defined and tested for their relationship to improved care; therefore, NCQA provider recognition is subject to change.

See "Other Reports on Health Care Quality" in the drop-down menu for Managed Behavioral Healthcare Organizations – for behavioral health accreditation and Credentials Verifications Organizations – for credentialing certification.

If you need this material translated into another language, please call Member Services at 1-888-982-3862.
Si usted necesita este material en otro lenguaje, por favor llame a Servicios al Miembro al 1-888-982-3862.

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