

Important disclosure information

Traditional Choice® indemnity

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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

Notice: You must personally bear all costs if you use health care not authorized by this plan or purchase drugs that are not authorized by this plan.

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.

Where to find information about your specific plan

Your plan documents list all the details for the plan you choose. This includes what's covered, what's not covered and what 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.

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 offered, underwritten and/or administered by Aetna Health Inc., Aetna Health Insurance Company and/or Aetna Life Insurance Company.

Get plan information online and by phone

If you're not yet enrolled in an Aetna® health plan

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.

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 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. Then visit **aetna.com** and click "Log In." Follow the prompts to complete the one-time registration.

Then you can log in anytime to:

- Verify who's covered and what's covered
- Access your plan documents
- Track claims or view past copies of Explanation of Benefits statements
- Learn more about and access any wellness programs that come with your plan

(2) Use your mobile device to access a streamlined version of our secure member website

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:

- 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 email

(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 to:

- 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 behavioral 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
- 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

What you pay

You will share in the cost of your health care. These are called out-of-pocket costs. These costs vary and your plan may not include all of them. 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.
- **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 for some services.

Help for those who speak another language and for those who are deaf

If you require language assistance, please call the Member Services number on your member ID card, and a 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 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.

Other deductibles may apply at the same time:

- **Inpatient hospital deductible** – Applies when you are a patient in a hospital
- **Emergency room deductible** – The amount you pay when you go to the emergency room, waived if you are admitted to the hospital within 24 hours

Note: These are separate from your general deductible. For example, your plan may have a \$1,000 general deductible and a \$250 emergency room deductible.

This means 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.

How we pay your doctors and other health care providers

Doctors and hospitals set the rates to charge you. It may be higher — sometimes much higher — than what your Aetna plan recognizes or allows. Your doctor may bill you for the dollar amount that the plan doesn't recognize. No dollar amount above the recognized charge counts toward your deductible or out-of-pocket limits. This means you are fully responsible for paying everything above the amount that the plan allows for a service or procedure.

We pay for your health care depending on the plan you or your employer chooses. Some of our plans pay for services by looking at what Medicare would pay and adjusting that amount up or down. Our plans range from paying 90 percent of Medicare (that is, 10 percent less than Medicare would pay) to 300 percent of Medicare (the Medicare rate multiplied by three). Some plans pay for services based on what is called the usual and customary charge or reasonable amount rate. These plans use information from FAIR Health, Inc., a not-for-profit company, that reports how much providers charge for services in any ZIP code.

You can call Member Services at the toll-free number on your Aetna ID card to find out the method your plan uses to reimburse doctors and other health care providers. You can also ask for an estimate of your share of the cost for services you are planning. See "Emergency and urgent care and after hours care" to learn 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. You usually only need precertification for more serious care like surgery or being admitted to a hospital. Your doctor may get precertification from us, but it's your responsibility to either call us or have your doctor call us for precertification when that's required.

Your plan documents list all the services that require you to get precertification. If you don't, you will have to pay for all or a larger share of the cost for the service.

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

You do not have to get precertification for emergency services.

What we look for when reviewing a request

First, we check to see that you are still a member. And we make sure the service is considered medically necessary for your condition. We also make sure the service and place requested to perform the service are cost effective. We may suggest a different treatment or place of service that is just as effective but costs less. We also look to see if you qualify for one of our care management programs. If so, one of our nurses may contact you.

Precertification 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.

Our review process after precertification (utilization review/patient management)

We have developed a patient management program to help you access appropriate health care and maximize coverage for those health care services. In certain situations, we review your case to be sure the service or supply meets established guidelines and is a covered benefit under your plan. We call this a utilization review.

We follow specific rules to help us make your health a top concern during our reviews

- We do not reward Aetna employees for denying coverage.
- We do not encourage denials of coverage. In fact, we train staff to focus on the risks of members not getting proper care. Where such use is appropriate, our staff uses 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.
- We do not encourage utilization decisions that result in underutilization.

Filing claims

You can download and print a claim form at <https://www.aetna.com/individuals-families/using-your-aetna-benefits/find-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 “Knowing what is covered” to learn more about coverage policies.

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 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, follow these guidelines:

- Call **911** or go to the nearest emergency room.
- You do not have to get approval for emergency services.

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.”*

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 ID card. We will help you determine if you need to pay that bill.

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 **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.

Prescription drug benefit

Check your plan documents to see if your plan includes prescription drug benefits.

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.

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 Pharmacy Drug Guide (formulary). This guide shows which prescription drugs are covered on a preferred basis. It also explains how we choose 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 us rebates when you buy certain drugs

We 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 Aetna 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.

Home delivery and specialty drug services are from pharmacies that Aetna owns

Aetna Rx Home Delivery® and Aetna Specialty Pharmacy®, are included in your network and provide convenient options for filling medicine you take every day or specialty medicines that treat complex conditions.

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 us 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.

You may request an exception for some drugs that are not covered

Your plan documents might list specific drugs that are not covered. Your plan also may not cover drugs that we haven't reviewed yet. You, someone helping you or your doctor may have to get our approval (a medical exception) to use one of these drugs. Get a copy of the preferred drug guide.

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.

You can find the Aetna Preferred Drug Guide on our website at [aetna.com/formulary/](https://www.aetna.com/formulary/). You can call the toll-free number on your Aetna ID card to ask for a printed copy. We frequently add new drugs to the guide. Look online or call Member Services for the latest updates.

Mental health and addiction benefits

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.

Aetna Behavioral Health offers two screening and prevention programs for our members

- **Beginning Right**® depression program: Perinatal and postpartum depression education, screening and treatment referral
- **OORS Program**: Opioid overdose risk screening program

Call Member Services to learn more about these programs.

Transplants and other complex conditions

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

Important benefits for women

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prosthesis
- Treatment of physical complications of the mastectomy, including lymphedema.

Benefits will be provided to a person who has already undergone a mastectomy as a result of breast cancer while covered under a different health plan. Coverage is provided 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 use these links to get more.

- Fact sheet from the U.S. Department of Health and Human Services:

https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet.html

- Pamphlet from the U.S. Department of Labor:

<https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/your-rights-after-a-mastectomy.pdf>

Oklahoma Breast Cancer Patient Protection Act

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

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

Adjustments made to the non-diseased breast must occur within 24 months of reconstruction of the diseased breast.

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 **treasury.gov/resource-center/sanctions/Pages/default.aspx**.

Other state-mandated benefits

In Connecticut, 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

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 unexpected bills with a simple call to Member Services. Call the toll-free number on your ID card to find out what's covered before you receive the care.

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. It might also be to treat an injury or illness.

The product or service:

- Must meet a normal standard of care 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 can decide if a treatment or service is not medically necessary. We do not reward Aetna employees for denying coverage. Sometimes a physician's group will determine medical necessity. 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. You can call Member Services to ask for a free copy of the materials we use to make coverage decisions. Or visit [aetna.com/about/cov_det_policies.html](https://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

We look at scientific evidence published in medical journals to help us 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. Our doctors may use nationally recognized resources like MCG (formerly Milliman Care Guidelines).

We also review the latest medical technology, including drugs, equipment and 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, including the federal Agency for Healthcare 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 aetna.com

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

CPBs help us decide whether to approve a coverage request. Your plan may not cover everything our CPBs say is medically necessary. Each plan is different, so check your plan documents.

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

You and your doctor can read our CPBs on our website at [aetna.com](https://www.aetna.com). You can find them under "Providers." No Internet? Call Member Services at the toll-free number on your 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 email Member Services through the secure website. If you're not satisfied after talking to a Member Services representative, you can ask us 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 we will respond.

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 our response to your appeal. Call Member Services to ask for an external review form. You can also visit aetna.com. Enter "external review" into the search bar.

You can get an outside review for most claims. If the reason for your denial is that you are no longer eligible for the plan, you may not be able to get an outside review.

Some states have a separate external review process. You may even need to pay a filing fee as part of the state mandated program. If your state does not have a separate external review process, then you would follow the federal external review process. 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.

In Indiana, visit in.gov/idoi/2547.htm for information about how you can file an internal or external grievance.

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 – or rush – review. That means we will make our decision as soon as possible.

Member Rights and Responsibilities

Know your rights

You have many legal rights and responsibilities. You have the right to suggest changes in our policies and procedures. This includes our member rights and responsibilities.

Some of your rights are below. We also publish a list of rights and responsibilities on our website. Visit aetna.com/individuals-families/member-rights-resources.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 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 directives¹:

- Durable power of attorney – names 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 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, bar associations, legal service programs 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.

¹Source: American Academy of Family Physicians. Advance 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 May 15, 2018.

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, including goals and outcomes, go to our website at [aetna.com](https://www.aetna.com). Enter "Quality Management and Improvement Efforts" in the search bar. You can also call Member Services to ask for a printed copy. The toll-free number is on your Aetna ID card.

We protect your privacy

We consider personal information to be private. Our policies protect your personal information from unlawful use. By personal information, we mean 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 our health plans or other related activities, we use personal information within our company, share it with our 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 we may use your information include:

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

We consider these activities key for the operation of our plans. When allowed by law, we use and disclose your personal information in the ways explained above without your permission. Our privacy notice includes a complete explanation of the ways we use and disclose your information. It also explains when we need your permission to use or disclose your information.

We are 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. We 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 ID card or visit us at [aetna.com](https://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.

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. 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.

Nondiscrimination for genetic testing

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

Hawaii Informed Consent

You have the right to be fully informed before making any decision about any treatment, benefit or nontreatment. Your 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.

More information is available

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

- A complete list of participating health care providers in the health care plan's service area
- 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. A description of the process for the selection of a PCP, any limitation on access to specialists, and the plan's standing referral policy
 5. The emergency coverage and benefits, including any restrictions on emergency care services
 6. The out-of-area coverage and benefits, if any
 7. The enrollee's financial responsibility for copayments, deductibles, premiums, and any other out-of-pocket expenses
 8. The provisions for continuity of treatment in the event a health care provider's participation terminates during the course of an enrollee's treatment by the provider
 9. 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
 10. 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
- A description of the financial relationship between the health plan and any health care provider, including, if requested, the percentage of copayments, deductibles, and total premiums spent on health care related expenses and the percentage of copayments, deductibles and total premiums spent on other expenses, including administrative expenses

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 you are entitled in the particular health plan that is covering or being offered to you; (2) a description of any limitations, exceptions or exclusions to coverage in the health benefit plan, including prior authorization policies, restricted drug formularies or other provisions that restrict your access to covered services or items; (3) a listing of the plans' participating providers, their business addresses and telephone numbers, their availability, and any limitation on your choice of provider; (4) notification in advance of any changes in the health benefit plan that

either reduces the coverage or increases the cost to you; and (5) a description of the grievance and appeal procedures available under the health benefit plan and your rights regarding termination, disenrollment, nonrenewal or cancellation of coverage. If you are a member, contact Member Services by calling the toll-free number on your ID card to ask for more information. If you are not yet an Aetna member, contact your plan administrator.

North Carolina

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

We are 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 listing 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 demonstrates 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 1-866-565-1236. Si usted necesita este material en otro lenguaje, por favor llame a Servicios al Miembro al 1-866-565-1236.

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call **1-888-982-3862**.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: **859-425-3379** (CA HMO customers: **860-262-7705**), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at **1-800-368-1019, 800-537-7697** (TDD).



TTY: 711

To access language services at no cost to you, call 1-888-982-3862 .

Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862 . (Spanish)

如欲使用免費語言服務，請致電 1-888-982-3862 。（Chinese）

Afin d'accéder aux services langagiers sans frais, composez le 1-888-982-3862 . (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-982-3862 . (Tagalog)

T'áá ni nizaad k'ehjí bee níká a'doowoł doo búááh ílínígóó koji' hólne' 1-888-982-3862 . (Navajo)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-982-3862 an. (German)

የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-888-982-3862 ይደውሉ። (Amharic)

(Arabic) . للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-888-982-3862

আপনাকে বিনামূল্যে ভাষা পরিষেবা পেতে হলে এই নম্বরে টেলিফোন করুন: 1-888-982-3862 | (Bengali)

आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, 1-888-982-3862 पर कॉल करें। (Hindi)

Iji nwetaòhèrè na orụ gasị asụsụ n'efu, kpọọ 1-888-982-3862 . (Ibo)

무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오. (Korean)

M dyi wuḍu-dù kà kò dò bě dyi múuñ nì Pídyi ní, nìí, dá nòbà nìà kε:1-888-982-3862. (Kru-Bassa)

(Persian-Farsi) برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-888-982-3862 تماس بگیرید.

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-982-3862 . (Russian)

(Urdu) بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-888-982-3862 پر بات کریں۔

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-982-3862 . (Vietnamese)

Lati wonú awon isẹ èdè l'ọfẹ fun ọ, pe 1-888-982-3862 . (Yoruba)

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.