Important information about your health benefits – Connecticut

Aetna Health Maintenance Organization (HMO) 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.

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 the plan includes those rules.

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 Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Group Insurance 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.

Getting help

Contact Member Services with questions
Call the toll-free number on your ID card. Or, call 1-800-US-Aetna (1-800-872-3862) Monday through Friday, 7 a.m. to 7 p.m. ET. 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 in.
Member Services can help you:

- 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

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

It’s important to know which doctors are in our network. That’s because some health plans only let you visit doctors, hospitals and other health care providers if they are in our network. Some plans allow you to go outside the network. But, you pay less when you visit doctors in the network.

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

- Log in to your secure Aetna Navigator® member website at www.aetna.com. Follow the path to find a doctor and enter your doctor’s name in the search field.
- Call us at the toll-free number on your Aetna ID card, or call us at 1-888-87-AETNA (1-888-872-3862).

For up-to-date information about how to find health care services, please follow the instructions above. If you would like a printed list of doctors, contact Member Services at the toll-free number on your Aetna ID card.

Our online directory 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
- Gender

You can even get driving directions to the office. If you don’t have Internet access, call Member Services to ask about this information.

Provider networks improve care while lowering costs

Members who receive care from providers from value-based arrangements are participating in a network designed to improve care while lowering costs. These networks may be set up in different ways, but all include primary care doctors and specialists. They also typically include at least one hospital.

Like most plans, we usually pay doctors and hospitals on a fee-for-service basis. This means your doctor or hospital still gets paid for each visit. However, the value-based network’s mission is to better coordinate patient care to improve efficiency, quality and patient satisfaction.

We agree with the network on certain goals, such as:

- Clinical performance goals – completing enough screenings for cancer, diabetes and cholesterol
- Cost-efficiency goals – reducing avoidable ER visits, short-term hospital stays, repetitive tests and the overall cost of care

We pay these value-based networks more when they meet certain goals. The amount of these payments depends on how well the network meets their goals. The network may also have to make payments to us if they fail to meet their goals.

In most of our arrangements we will reward the network financially for both efficient care and higher quality of care. This helps encourage savings that are tied to value and better health outcomes for our members.

Doctors and hospitals that are members of a value-based (accountable care) network may have their own financial arrangements through the network itself. Ask your doctor for details.

Choose a doctor the fast and easy way with DocFind®. Simply log on to your secure Aetna Navigator® website at www.aetna.com and select “Find a Doctor, Pharmacy or Facility.” After entering your search criteria, look for the ACO logo. If you need a printed directory instead, call the Member Services phone number on your member ID card.

*The specific goals will vary from network to network.

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

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

Language hotline – 1-888-982-3862 (140 languages are available, 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)
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:

<table>
<thead>
<tr>
<th>Copay</th>
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<tbody>
<tr>
<td>A set amount (for example, $15) you pay for 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</td>
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Other copays may apply at the same time:

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<th>Inpatient Hospital Copay</th>
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<tr>
<td>This copay applies when you are a patient in a hospital.</td>
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<th>Emergency Room Copay</th>
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<tr>
<td>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.</td>
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<th>Coinsurance</th>
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<td>Your share of the costs for a covered service. This is usually 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.</td>
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<th>Deductible</th>
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<td>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.</td>
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Costs and rules for using your plan

Your costs when you go outside the network
HMOs 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. See “Emergency and urgent care and care after office hours” for more.

Going in network just makes sense.
• We have negotiated discounted rates for you.
• In-network doctors and hospitals won’t bill you for costs above our rates for covered services.
• You are in great hands with access to quality care from our national network.

Choose a primary care physician
You can 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 we 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. 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.

A female member may choose an Ob/Gyn as her PCP. You may also choose a pediatrician for your child(ren)’s PCP. Your Ob/Gyn acting as your PCP will provide the same services and follow the same guidelines as any other PCP. He or she will issue referrals to other doctors (if your plan requires referrals). He or she will also get approvals you may need and comply with any treatment plans you are on. See the sections about referrals and precertification for more information.

Tell us who you choose to be your PCP
Each member of the family may choose 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 us 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 will 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.
• 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.
• In network-only plans, you can get a special referral if a network specialist is not available. You are required to get approval from us when you get a referral to an out-of-network specialist.

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 us 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 choose an Ob/Gyn as her PCP. Women can also 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. When you get care from a doctor in the Aetna network, your doctor gets precertification from us. But if you get your care outside our network, you must call us for precertification when that’s required.

Your plan documents list all the services that require you to get precertification. If you don’t, you will have to pay for all or a larger share of the cost for the service. Even with precertification, you will usually pay more when you use out-of-network doctors.

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 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.

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. 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.

How we cover out-of-network emergency care

You are covered for emergency and urgently needed care. You have this coverage while you are traveling or if you are near your home. That includes students who are away at school. When you need care right away, go to any doctor, walk-in clinic, urgent care center or emergency room. We’ll review the information when the claim comes in. If we think the situation was not urgent, we might ask you for more information and may send you a form to fill out. Please complete the form, or call Member Services to give us the information over the phone.

Follow-up care for plans that require a PCP

If you use a PCP to coordinate your health care, your PCP should also coordinate all follow-up care after your emergency. 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. Your PCP should coordinate all follow-up care. 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 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 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, 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 company rebates
Drug companies may give us rebates when our members buy certain drugs. We may share those rebates with your employer. Rebates usually apply to drugs on the preferred drug list. They may also apply to drugs not on the list. In plans where you pay a percent 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 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 from Aetna-owned pharmacies
Mail-order and specialty drug services are from pharmacies that 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 list
Sometimes your doctor might recommend a drug that’s not on the preferred drug list. 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 have to try one or more 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, 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 we haven’t reviewed yet. You, someone helping 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
You can find the Aetna Preferred Drug Guide on our website at www.aetna.com/formulary/. You can also ask for a printed copy by calling 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.

Mental health and addiction benefits
You must use therapists and other mental health professionals who are in the Aetna network. Here’s how to get 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
We want you to feel good about using the Aetna network for mental health services. Visit www.aetna.com/docfind and click the “Get info on Patient Safety and Quality” link. No Internet? Call Member Services instead. Use the toll-free number on your Aetna ID card to ask for a printed copy.

Mental health programs to help prevent depression
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
Call Member Services for more information on either of these prevention programs. Ask for the phone number of your local Care Management Center.

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 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.

Breast reconstruction benefits
Notice regarding 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:
• All stages of reconstruction of the breast on which a mastectomy has been performed
• Surgery and reconstruction of the other breast to produce a symmetrical appearance
• Prostheses
• Treatment of physical complications of all stages of mastectomy, including lymph edemas

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.
We will talk to you and your doctor about these rules when we provide the coverage. We will also follow your plan design. For example, the following may apply to your breast reconstruction benefits as outlined in your plan design:

• Limitations  
• Copays  
• Deductibles  
• Referral requirements

If you have any questions about this coverage, please contact the Member Services number on your ID card.

Also, you can visit the following websites for more information:


Religious Exemption

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

Please refer to your plan administrator for specifics regarding your benefits.

Knowing what is covered

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  
• 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 www.aetna.com/about/cover_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. 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

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 www.aetna.com. You can find them 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 product or service.

Avoid unexpected bills. Check your plan documents to see what’s covered before you get health care. Can’t find your plan documents? Call Member Services to ask a specific question or have a copy mailed to you.
We can help when more serious care is recommended

We may review a request for coverage to be sure the service is in line with recognized 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 make sure it is necessary for you to be in the hospital. We look at the level and quality of care you are getting.

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’re home.

Third, we may review your case after your discharge. 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:

• 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 claims. Physician’s groups, such as independent practice associations, may use other resources 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 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 us to send your issue 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

Connecticut External Review – After you have exhausted the Aetna internal appeal process described above, you or a provider acting on your behalf may make a request to the Connecticut Insurance Department for an expedited external review without exhausting our internal appeal process.

Aetna External Review – As an alternative, you can ask Aetna to coordinate 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 in to www.aetna.com/individuals-families-health-insurance/member-guidelines/ext_review.html.

If your case qualifies, 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.

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 we will make our decision as soon as possible.

What to do when a dependent child is no longer eligible for coverage

Connecticut law allows special provisions for dependent children who are no longer eligible for coverage due to any of the following reasons:

• The child marries

• Ceases to be a resident of the state (does not apply to a dependent child under age 19 or a full-time student attending an accredited institution of higher education)

• Becomes covered under a group health plan through the dependent’s own employment

• Attains the age of 26

If a child dependent’s coverage is terminated, there is an option under the plan to continue the child’s coverage for the longer of:

1. The end of the month following the month in which the child attains the limiting age, or

2. For the period set forth in COBRA/state continuation

Since most often the period for COBRA/state continuation (option 2) will be the longer of the two periods, we will process the termination of the dependent child’s coverage effective at the end of the month in which the dependent child’s coverage termination event occurred. COBRA/state continuation will begin thereafter.

However, if you choose to elect option (1) as described above, you must notify your employer. Your employer will then notify us so that we can process your election appropriately. Please note: If you elect option (1), COBRA/state continuation will not be available at the end of that period.

The options and procedures described above also apply to an employee’s spouse upon divorce, court ordered annulment or separation.

If your dependent child is handicapped on the date coverage would otherwise terminate, he/she may be able to continue coverage if you provide documentation of this status within 31 days of the date on which the child’s coverage would have terminated in the absence of the handicap.

You can get the forms you need to continue coverage by calling Member Services at the toll-free number on your member ID card. Complete and return the forms within 31 days of the date on which the child’s coverage would have terminated in the absence of the handicap.

If your dependent is not handicapped and you would like information on continuing coverage for him or her within our service area, please contact your benefits administrator.

Medical Loss Ratios

The medical loss ratio is the ratio of incurred claims to earned premium for the prior calendar year for managed care plans issued in Connecticut. It includes claims for medical expenses for services and supplies provided to enrollees. It does not include expenses for stop loss, reinsurance, enrollee educational programs or other cost containment programs or features.

Aetna Health Inc.
  For Medical 87.5%
  Dental Standalone 101.74%

Aetna Life Insurance Company (ALIC)
  For Aetna Life Insurance Company Medical 82.75%
  Dental Standalone 79.7%
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. 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 www.aetna.com. Click on “Rights & Resources” on the home page 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 – 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 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.


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. Enter “commitment to quality” in the search bar. You can also call Member Services to ask for a printed copy. See “Contact Member Services with questions” on page 2.

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 about your physical or mental health
• Information about the health care you receive
• Information about what your health care costs

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
• 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
• Vendors
• Government authorities
• Third party administrators

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 health plans. If allowed by law, we usually will not ask if it’s okay to use your information. However, we will ask for your permission to use your information for marketing purposes. We have policies in place if you are unable to give us permission to use your information. We are required to give you access to your information. You may also request corrections to your personal information. We must fulfill your requests within a reasonable amount of time.

If you’d like a copy of our privacy policy, call the toll-free number on your 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.

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).

Getting proof that you had previous coverage
We may ask for proof that you had previous coverage when you apply. Other insurers may do the same. This helps determine if you are eligible for the 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.

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.
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 listing of health plans and their NCQA status can be found on the NCQA website located at reportcard.ncqa.org.

To refine your search, we suggest you search these areas: Managed Behavioral Healthcare Organizations – for behavioral health accreditation; Credentials Verification Organizations – for credentialing certification; Health Insurance Plans – for HMO and PPO health plans; Physician and Physician Practices – for physicians recognized by NCQA in the areas of heart/stroke care, diabetes care, back pain and medical home. Providers who have been duly recognized by the NCQA Recognition Programs are annotated in the provider listings section of the Aetna provider directory.

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.

Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice.

Aetna does not provide care or guarantee access to health services. For up-to-date information, please visit our DocFind® directory at www.aetna.com or, if applicable, visit the NCQA’s new top-level recognition listing at recognition.ncqa.org.

If you need this material translated into another language, please call Member Services at 1-800-323-9930. Si usted necesita este material en otro lenguaje, por favor llame a Servicios al Miembro al 1-800-323-9930.

www.aetna.com