

The following documents were developed and intended for use as a complete enrollment package. By distributing, posting, printing, downloading, or viewing the enrollment package, you agree that the components may not be modified, omitted or used independently of one another. Your distribution, posting, printing, downloading, or viewing also memorializes your agreement that Aetna Inc. is not responsible for any miscommunication resulting from the separation of these documents.

**Aetna Affordable Health Choices®
limited benefits insurance plan***

Questions and Answers

Membership information you need to know

How do I decide if this plan is right for me?

Please read the information in this enrollment kit, including your Benefits Summary, which explains some of the benefits, limitations, features, and exclusions of this plan. Consider the amount you will pay in premiums, as shown on the Enrollment/Change Request form, and compare this plan to any other medical coverage options you may have. If you have any questions or need additional information, please call us toll-free at **1-888-772-9682**.

How do benefit limits work?

Limits put a cap or ceiling on what the plan will pay. Some benefits have a limit on the dollar amounts and others on the number of services, or both. The plan will not pay for a service or supply once you have reached a limit on either the dollar amounts or the number of services for that service or supply. Because there are limits on what is paid for certain kinds of services or visits, you may not be covered for some services or visits even though you have not reached your overall maximum. Your Benefits Summary, found in this enrollment kit, explains these limits, maximums, and other features of your plan, such as copays and deductibles. Please read it carefully so that you understand what your plan will pay before you enroll.

Who can enroll?

All members of the Association of National Park Rangers are eligible to enroll. If you are an eligible member, you can also enroll your eligible dependents (except for Short Term Disability). Your eligible dependents are your lawful spouse and your children from birth until age 26, through any age if handicapped and unable to earn a living, or until they can no longer be legally declared as dependents. Dependent age and status requirements may vary by state.

Please make checks payable to ANPR and forward along with your Enrollment/Change Request form to: ANPR, 25958 Genesee Trail Road, PMB 222, Golden, CO 80401.

When does coverage begin?

Coverage is effective on the first day of the month after you enroll.

When do maximums and deductibles reset?

Annual deductibles, maximums, and limits add up throughout the coverage year, then reset and begin again on the anniversary date of your coverage year, March 1.

Will I get ID cards?

If you choose medical and/or dental coverage, you will get plastic member identification (ID) cards. Until you get your plastic IDs, please use the temporary member ID at lower right. This ID is valid after you enroll and your coverage begins.

How do I file a claim?

Claim forms are available from www.aetna.com/docfind/custom/aahc, by calling SRC toll-free at **1-888-772-9682**, or by writing to Strategic Resource Company, Attn: Claims Department, P.O. Box 14079, Lexington, KY 40512-4079.

If you do not enroll now, you cannot enroll until the next open enrollment, unless you have a qualifying life event.



You have a limited time to enroll.

IMPORTANT HEALTH CARE REFORM NOTICE: SPECIAL ENROLLMENT OPPORTUNITY FOR DEPENDENTS UP TO AGE 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the Aetna Affordable Health Choices plan. Individuals may request enrollment for such children for 30 days from the date they receive this notice. Enrollment will be effective retroactively to the first day of the first plan year beginning on or after September 23, 2010. For more information contact SRC at **1-888-772-9682**.

**Just hired?
You have 30 days from the date you are hired to enroll.**

Cut out your temporary member identification along the dotted line.

			
MEDICAL/DENTAL PPO		An Aetna Company	
ASSOCIATION OF NATIONAL PARK RANGERS COMPANY NO.: 801101		AETNA AFFORDABLE HEALTH CHOICES® PPO	
MEMBER NAME: _____		BIN# 610502 RX	
AND COVERED DEPENDENTS _____			
FOR MEMBER SERVICES CALL		1-888-772-9682	
PAYOR NUMBER 57604 0039			

* Except in NY, this plan is filed as a major medical plan that contains an annual benefit maximum and a number of additional coverage limitations and exclusions.



www.aetna.com/docfind/custom/aahc

HEALTH CARE PROVIDER: The person listed on the front of this card has been enrolled under a limited major medical plan sponsored by the employer listed on the front of this card. Covered members are entitled to benefits under the applicable plan, subject to exclusions and limitations. This card does not guarantee coverage. For verification of coverage, filing a claim or for questions other than the discount programs, contact us at the number printed on the front of this card or mail us at the address below.

INSURED: Network physicians, hospitals, and other health care providers are independent contractors and are neither agents nor employees of Aetna Life Insurance Company.

EMERGENCY URGENT CARE: Call your local emergency hotline (ex.911) or go to the nearest emergency facility. For AETNA VISION DISCOUNTS call 1-800-793-8616. For LASIK call 1-800-422-6600. For CONTACTS DIRECT call 1-800-391-5367.

Strategic Resource Company
P.O. Box 14079
Lexington, KY 40512-4079

Notice to members concerning health care services: *Your share of the payment for health care services may be based on the agreement between your health plan and your provider. Under certain circumstances, this agreement may allow your provider to bill you for amounts up to the provider's regular billed charges.*

More questions?

*To get help in any language, call toll-free **1-888-772-9682** Monday through Friday, 8 a.m. to 8 p.m. Eastern Time.*

¿Tiene más preguntas?

*Si necesita ayuda en cualquier idioma, llame sin cargo al **1-888-772-9682** de lunes a viernes de 8 a.m. a 8 p.m., hora del Este.*

Insurance Plans are underwritten by Aetna Life Insurance Company. Plans are administered by Strategic Resource Company (SRC). Aetna Affordable Health Choices® is a registered service mark of Aetna Inc. Health insurance plans contain exclusions and limitations. Information is believed to be accurate as of the production date; however, it is subject to change. For OK residents only, policy forms issued include GR-9/GR-9N and GR-29/GR-29N.



Take charge of your health

Aetna Affordable Health Choices®
Limited Benefits Insurance Plan*

Affordable coverage
Special discounts
Information and
tools to make
healthy decisions

*In all states except NY, this plan is filed as a major medical plan that contains an annual benefit maximum and a number of additional coverage limitations and exclusions.

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We want you to know®





Good health is important to you and your

Make the easy ch

They say nothing is more important than your health

They're right. And that's what makes health insurance such an essential part of your life. It's time to take charge of your health and your health insurance needs.

At Aetna, we're here to help. Your employer is offering you Aetna Affordable Health Choices® limited benefits insurance plan. "Limited" means that the plan has a number of specific limits and other restrictions on visits, services and/or the dollar amounts covered under the plan in addition to the overall dollar limit of the policy. Once these limits have been reached, the plan will not pay any more towards the cost of the service in question, and you will be responsible for the remaining unpaid charges or expenses. Your Benefits Summary explains these visit and service limits, the overall annual benefit maximum, and other cost-sharing features of your plan, such as copayments and deductibles. Please read it carefully so that you understand the limits to what the plan will pay before you enroll.

Take charge of your health — enroll today!

We're here to help

When you enroll in the Aetna Affordable Health Choices limited benefits insurance plan, you're gaining a lot of advantages. Some of these are:

Easy to understand

Yes, insurance can be simple. We provide you with straightforward language and easy-to-understand benefits. If you have any questions, just call us or check us out on the web at www.src-web.com.

Easy to choose

We'll guide you through the process step by step. Aetna's participating provider network (PPO) offers you a wide selection of doctors and hospitals.

Easy to afford

You choose from the options available to you in your plan, and your premiums are simply deducted from your pay. As an Aetna member, you are also entitled to discounts.** It's one more way we help you maintain a healthy lifestyle.

Easy to manage

Thanks to easy-to-use web-based tools, you can get valuable health-related information and quickly locate Aetna network doctors in your area.

Find a doctor — DocFind makes it easy!

With our DocFind® online directory, you can customize your search by specialty and location. Looking for a pediatrician within your zip code? How about a doctor affiliated with a nearby hospital? It's all here — plus maps and directions to a doctor's office. DocFind even lets you search by a doctor's gender and languages spoken. Just visit www.aetna.com/docfind/custom/aahc.



Insurance plans are underwritten by Aetna Life Insurance Company. Plans are administered by Strategic Resource Company (SRC).

choice today!

How it works

You'll like visiting a network doctor, but you'll also like knowing it's your choice

See a network doctor ... lower costs, hassle-free access

Visit any preferred provider without a referral. You'll have confidence knowing that anyone you choose measures up to our strict credentialing standards.

- Your plan may include an annual **deductible** (the amount of money you must pay for eligible expenses during each coverage year before the plan begins to pay benefits).
- Once your deductible is met, you'll pay a percentage of the remaining covered expenses. For some visits, services or other charges you may pay a **copay** (an initial amount of a medical provider's fee that you are responsible for paying each time you incur certain covered charges, usually paid when the charges are incurred).
- On average, you'll enjoy lower costs since network doctors have agreed to offer Aetna members negotiated fees (generally lower than the doctor's usual charges).
- Your network doctor will submit your claims for you.

See any doctor ... the choice is yours

It's all about your freedom to choose. Visit any licensed doctor or specialist — there are no network restrictions and no referrals. You may need to:

- Meet an annual deductible (generally higher than the deductible set for services received from a network doctor).
- Then pay a percentage of the remaining covered expense at the time of service. This percentage may be higher than you would pay in-network at a preferred provider. For some visits, services or other charges you may pay a copay.
- File your own claims.
- Pay the difference between the amount covered by your plan and the amount charged by the doctor. This can increase your out-of-pocket costs because the doctor has not agreed to negotiated fees with Aetna.

I want good health.
I like the plan.
I want to get started!

What do I do next?

- Read all the materials in your enrollment kit.
- Follow the step-by-step instructions and enroll today!

Language assistance

If you need assistance in any language, please call Member Services at 1-888-772-9682.

Su necesita asistencia en cualquier idioma, por favor llame a Servicios al Cliente al 1-888-772-9682.



Coverage you need
Coverage you
can afford
Enroll today!

Discounts and programs to help maintain a healthy lifestyle

Your medical membership includes special programs* and discounts** with a wealth of features. These programs include savings on products and educational materials geared toward particular health needs. Here are a few of the ways we can help you maintain a healthy lifestyle:

Weight management discount program

You and your eligible family members can save on weight-loss programs and products from one of the largest weight management firms worldwide — Jenny Craig®. You'll get a sensible weight-loss plan, one-on-one weekly consultations and discounts on weight-loss products that fit your lifestyle.

Hearing discount program

Receive a discount** on hearing exams and services with HearPO® at participating locations nationwide.

Oral health care discounts

Receive savings on products and services to help improve dental and overall health.

Aetna pharmacy management

In addition to prescription discounts, we help protect your health by providing information to help control certain medical conditions.

Aetna Natural Products and ServicesSM program

Professional services** offered at reduced rates — from natural therapy professionals, which include acupuncturists, chiropractors, massage therapists and nutritional counselors.

Discounts on health-related products*

including over-the-counter vitamins, herbal and nutritional supplements and natural products.

Fitness program

Enjoy discounted rates on memberships at participating health clubs contracted with GlobalFit™ as well as savings on home exercise equipment.

Aetna VisionSM Discounts

Receive discounts** on eyewear, contact lenses, LASIK eye surgery and eye care accessories. Participating optical centers include Sears Optical®, LensCrafters®, Target Optical® and many Pearle Vision® locations.

To learn more about these programs and discounts, go to www.aetna.com/docfind/custom/aahc or call the Member Services number at 1-888-772-9682.

* These discount programs are rate-access programs and may be in addition to any plan benefits. Discount and other similar health programs offered hereunder are not insurance. Program features are not guaranteed under the plan contract and may be discontinued at any time. Program providers are solely responsible for the products and services provided hereunder. Aetna does not endorse any vendor, product or service associated with these programs. It is not necessary to be a member of an Aetna plan to access the program participating providers.

** Discounts are from the provider's usual fee for the service (retail price). These discount programs are not insured benefits, but provide access to discount programs maintained by Aetna Inc. and its affiliates.

This material is for information only. 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. Health insurance plans contain exclusions and limitations. Discount programs provide access to discounted prices and are not insured benefits. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions.

Policy form numbers issued in OK include: GR-9/GR-9N, GR-29/GR-29N.

BENEFITS SUMMARY**Aetna Affordable Health Choices[®] limited benefits insurance plan**

(Except in New York, this plan is filed as a major medical plan that contains an annual benefit maximum and a number of additional coverage limitations and exclusions.)

**Plan design and benefits provided by Aetna Life Insurance Company (Aetna)
and administered by Strategic Resource Company (SRC).**

Unless otherwise indicated, all benefits and limitations are per covered person. Where a benefit is expressed as a percentage, the lower of the negotiated charge(s) or the recognized charge(s) will be the basis of payment.

Inside this Benefits Summary:

- Medical
- Hospital Indemnity
- Dental
- Vision Care
- Short Term Disability (STD)
- Term Life and Accidental Death Insurance

PLEASE READ CAREFULLY BEFORE DECIDING WHETHER THIS PLAN IS RIGHT FOR YOU:

- This plan will not pay more than the overall maximum benefit in a coverage year.
- This plan also limits what it will pay for particular kinds of services in addition to the overall annual maximum benefit.
- Once any of these limits have been reached, the plan will not pay any more towards the cost of the service in question, and your health care providers can bill you for what the plan does not pay. Many illnesses cost much more to treat than this plan will cover.
- The Colorado Health Benefit Plan Description Form(s) and this Benefits Summary explains these limits, the overall annual maximum benefit, and other cost sharing features of your plan, such as copayments and deductibles. See the full plan for more information.

Aetna will pay benefits only for expenses incurred while this coverage is in force, and only for the medically necessary treatment of injury or disease. The coverage displayed in this Benefits Summary reflects certain mandate(s) of the state in which this policy was written. However, certain federal laws or other mandate(s) in the state you live and/or work could also affect how this coverage pays.

This health insurance issuer believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). Being a grandfathered health plan means that your plan does not include certain consumer protections of the Affordable Care Act. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at **1-888-772-9682**. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at **1-866-444-3272** or **www.dol.gov/ebsa**.

Medical

Medical coverage is described in the Colorado Health Benefit Plan Description Form(s) included in this enrollment kit. Please read the form(s) carefully so that you understand benefits, limits, and exclusions of the plan before you enroll.

When you enroll in medical coverage, you also receive:**Aetna VisionSM Discounts***

Aetna VisionSM Discounts uses the nationwide EyeMed Select Network of vision care providers to offer you and your family glasses, contact lenses, nonprescription sunglasses, contact lens solutions and other eye care accessories at discounted prices. Plus, you can receive discounts on eye exams and LASIK eye surgery. For exams and eyewear call **1-800-793-8616**. For contacts call **1-800-391-5367**. For LASIK customer service call **1-800-422-6600**. You can also locate a local provider by visiting www.aetna.com/docfind/custom/aahc. This discount arrangement may not be available to **Illinois** residents.

Prescription drug discount program*

The prescription drug discount program gives you and your family access to over 59,000 retail pharmacies nationwide including major pharmacy chains and independent pharmacies (Aetna Network Pharmacy Database - 3/20/08). You can also use our Aetna Rx Home Delivery[®] service; a fast, easy way to fill the prescriptions you take regularly. To locate a participating pharmacy, call **1-888-772-9682** or visit www.aetna.com/docfind/custom/aahc.

*Discount programs provide access to discounted prices and are not insured benefits.

Medical Exclusions and Limitations

This plan does not cover all health care expenses and has exclusions and limitations. Members should refer to their booklet certificate to determine which health care services are covered and to what extent. The following is a **partial list** of services and supplies that are generally *not covered*. **However, your plan may contain exceptions to this list based on state mandates or the plan design purchased.**

Medical Exclusions:

Please refer to the Colorado Health Benefit Plan Description Form(s) included in this enrollment kit.

Other available coverage:**Hospital Indemnity**

Lump-sum benefit	\$1,000 for one stay in the hospital as an inpatient per coverage year; plus
Daily benefit	\$100 per day, for up to 100 days that you are an inpatient in a hospital per coverage year.

This benefit applies if you or a covered dependent are admitted to the hospital as an inpatient.

Coverage is not available if you live and work in **New Hampshire**.

This limited health plan does not meet **Massachusetts** Minimum Creditable Coverage standards.

Hospital Indemnity Plan Limitations and Exclusions:

This plan does not cover all health care expenses and has exclusions and limitations. Members should refer to their booklet certificate to determine which health care services are covered and to what extent. The same limitations and exclusions apply as those listed for the medical and/or dental coverage (if offered under your plan). **However, your plan may contain exceptions to this list based on state mandates or the plan design purchased.**

Vision Care

Eye Exams	Reimbursements of up to \$100 every 12 months for an exam, frames, lenses, or contact lenses.
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Fees for other services must be paid by you. Benefit period is 12 consecutive months beginning on the later of your effective date or your most recent eye exam covered under this plan. Coverage is not available if you live and work in **New Hampshire**. This limited health plan does not meet **Massachusetts** Minimum Creditable Coverage standards.

When you enroll in Vision Care coverage, you also receive:

Aetna VisionSM Discounts*	Aetna Vision SM Discounts uses the nationwide EyeMed Select Network of vision care providers to offer you and your family glasses, contact lenses, nonprescription sunglasses, contact lens solutions and other eye care accessories at discounted prices. Plus, you can receive discounts on eye exams and LASIK eye surgery. For exams and eyewear call 1-800-793-8616 . For contacts call 1-800-391-5367 . For LASIK customer service call 1-800-422-6600 . You can also locate a local provider by visiting www.aetna.com/docfind/custom/aahc .
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*Discount program provides access to discounted prices and is not an insured benefit. This discount arrangement may not be available to **Illinois** residents.

Vision Care Exclusions:

This plan does not cover all health care expenses and has exclusions and limitations. Members should refer to their booklet certificate to determine which health care services are covered and to what extent. The following is a **partial list** of services and supplies that are generally *not covered*. **However, your plan may contain exceptions to this list based on state mandates or the plan design purchased.**

- Orthoptic vision training, subnormal vision aids, any associated supplemental testing.
- Medical and/or surgical treatment of the eyes or supporting structure.
- Any eye or vision examination, or any corrective eyewear, required by an employer as a condition of employment.

Dental

Maximum benefit per coverage year	\$500
Deductible per coverage year	\$50
Preventive services (includes checkups and cleanings)	You are responsible for paying up to 20% [†] of the Recognized Charges . These services have no waiting period.
Basic services (includes fillings, oral surgery, and denture, crown and bridge repair)	You are responsible for paying up to 40% [†] of the Recognized Charges . You need to be enrolled in the dental plan without interruption for 3 months before the plan begins to pay for these services.
Major services (includes Perio and Endodontics, crowns, bridges, and dentures)	You are responsible for paying up to 50% [†] of the Recognized Charges . You need to be enrolled in the dental plan without interruption for 12 months before the plan begins to pay for these services.

[†] The percentage of the cost that you are responsible for paying a preferred provider is based on a **Negotiated Charge**. This percentage could be lower if you use a participating PPO network dentist (based on provider and location). The percentage of the cost that you are responsible for paying a non-preferred provider is based on a **Recognized Charge**. A non-preferred provider may require that you pay more than the **Recognized Charge**, and this additional amount would be your responsibility. The dental PPO network is not available in **Alabama, Arkansas, Idaho, Hawaii, Louisiana, Mississippi, New Mexico, or Puerto Rico**. This limited health plan does not meet **Massachusetts** Minimum Creditable Coverage standards. To locate a preferred provider, call toll-free **1-888-772-9682** or visit **www.aetna.com/docfind/custom/aahc**.

Dental Exclusions:

This plan does not cover all health care expenses and has exclusions and limitations. Members should refer to their booklet certificate to determine which health care services are covered and to what extent. The following is a **partial list** of services and supplies that are generally *not covered*. **However, your plan may contain exceptions to this list based on state mandates or the plan design purchased.**

The following charges are not covered under the dental plan, and they will not be recognized toward satisfaction of any deductible amount.

- Cosmetic procedures unless needed as a result of injury.
- Any procedure, service or supplies that are included as covered medical expenses under another group medical expense benefit plan.
- Prescribed drugs, pre-medication, analgesia or general anesthesia.
- Services provided for any type of temporomandibular (TMJ) or related structures, or myofascial pain.
- Charges in excess of the **Recognized Charge**, based on the 80th percentile of the Ingenix Medical Data Research Tables.

Short Term Disability (STD)

Benefit Period	Weekly benefits for up to 6 months while you are disabled.
Benefit Amount	50% of base pay received from the employer that sponsors this program (includes reported tips, but not overtime) up to \$125 maximum weekly benefit.
Waiting Period	Benefits begin after 14 days (plan pays immediately if hospitalized).
Coverage for employee only; coverage is not available if you work in California, Hawaii, New Jersey, New York, Rhode Island, and Puerto Rico.	

Short Term Disability Exclusions:

This plan does not cover all circumstances and has exclusions and limitations. Members should refer to their booklet certificate to determine which circumstances are covered and to what extent. The following is a **partial list** of circumstances that are generally *not covered*. **However, your plan may contain exceptions to this list based on state mandates or the plan design purchased.**

- Attempted suicide, while sane or insane, or intentional self-inflicted injury or sickness, unless as the result of a medical condition.
- Commission of or attempt to commit an act which is a felony in the jurisdiction in which the act occurred.
- Substance abuse.
- Occupational injury or sickness.

Term Life and Accidental Death Insurance

Employee term life benefit	\$20,000
Employee accidental death benefit	\$20,000
Optional dependents coverage	\$2,500 in term life for dependents over 6 months of age. \$500 for children from birth through 6 months of age.

Benefits paid to the beneficiary of your choice; benefits reduced by 50% when you reach age 70.

Term Life and Accidental Death Exclusions:

This plan does not cover all circumstances and has exclusions and limitations. Members should refer to their booklet certificate to determine which circumstances are covered and to what extent. The following is a **partial list** of circumstances that are generally *not covered*. **However, your plan may contain exceptions to this list based on state mandates or the plan design purchased.**

Term Life Exclusions:

- Suicide or attempted suicide (while sane or insane).

Accidental Death Benefit Exclusions:

- Use of alcohol, intoxicants, or drugs, except as prescribed by a physician.
- Suicide or attempted suicide (while sane or insane).
- An intentionally self-inflicted injury.
- A disease, ptomaine or bacterial infection except for that which results directly from an injury.
- Medical or surgical treatment except for that which results directly from an injury.
- Voluntarily inhalation of poisonous gases.
- Commission of or attempt to commit a criminal act.

Terms defined

A service or supply is **medically necessary** if it is determined by Aetna to be appropriate for the diagnosis, care or treatment of the disease or injury involved. See the plan documents for the complete definition.

A **copayment** (or **copay**) is a fixed amount that you must pay for a medical service after you have met any deductible. In some cases, you may be responsible for paying a copay as well as a percentage of the remaining charges.

In many instances, the plan requires that a deductible is met before a benefit is paid. A **deductible** is the amount you must pay for eligible expenses before the plan begins to pay benefits. A deductible may be per service, per visit, per supply or per coverage year. Preferred and non-preferred (in-network and out-of-network) deductibles must be met separately. Covered expenses in-network do not count towards the out-of-network deductible, and covered expenses out-of-network do not count towards the in-network deductible.

Once the **family deductible** per coverage year is met, all family members will be considered to have met their deductible. You will have met your **family deductible** when two covered family members have each fully paid their own deductibles in a coverage year.

Inpatient charges are all charges incurred when you are admitted as an inpatient at a hospital or other inpatient facility, including hospital room and board charges (daily room rate), Inpatient Professional Services, and Other Hospital Services.

Other Hospital Services are charges for certain services and supplies billed by a hospital when you are admitted as an inpatient, other than those charges for room and board. These charges may be significant and may include, but are not limited to: pharmaceutical, medical and surgical supplies and devices; lab tests and x-rays; and operating and recovery room expenses.

Inpatient Professional Services are charges billed by surgeons, physicians, radiologists, pathologists and anesthesiologists for services provided during an inpatient stay.

Outpatient charges are charges billed for services and supplies provided at doctors' offices, free-standing clinics and outpatient facilities. They also include charges at a hospital when you are not admitted as an inpatient, including emergency room charges.

A **negotiated charge** is the maximum amount that a preferred provider has agreed to charge for the visit, service, or supply. You should not have to pay more than your portion of the negotiated charge (subject to your plan limits).

A **recognized charge** is the amount that Aetna recognizes that a visit, service, or supply should cost, whether from a preferred or non-preferred provider. A non-preferred provider may require that you pay more than the recognized charge, and this additional amount would be your responsibility.

Percentage of remaining charges you pay refers to the percentage of **Negotiated or Recognized Charges** you pay after you have fulfilled the deductible and/or copay and before the benefit maximum is reached. This is also known as member coinsurance. A non-preferred provider may require that you pay more than the **Recognized Charge**, and this additional amount would also be your responsibility. Once the applicable benefit maximum has been reached, you will be responsible for 100% of the remaining balance.

Wellness visits are those visits to the doctor for services that are not for the purpose of diagnosing or treating an injury or disease. Some common types of wellness visits are annual physical exams, gynecological exams, well-baby or well-child visits, mammograms, some cancer screenings, and bone mass density measurements. Included as part of the wellness visit are x-rays, lab and other tests, and materials for the administration of immunizations and testing for tuberculosis.

Your plan might not offer a wellness visit(s) benefit. Please refer to the benefits chart in this Benefits Summary. Some federal and state laws mandate certain preventive exams that are to be covered by, or in addition to, this benefit if offered under your plan. If a wellness visit(s) benefit is not offered under your plan (see the benefits chart), these mandates will be covered by other benefits under your plan. Please refer to the plan documents for more information.

Questions and answers

How do benefit limits work?

Limits put a cap or ceiling on what the plan will pay. Some benefits have a limit on the dollar amounts and others on the number of services, or both. The plan will not pay for a service or supply once you have reached a limit on either the dollar amounts or the number of services for that service or supply. Because there are limits on what is paid for certain kinds of services or visits, you may not be covered for some services or visits even though you have not reached your overall maximum. **Before you enroll in the plan, please read the benefits chart in the Colorado Health Benefit Plan Description Form, carefully to understand these limits and consider what effects they may have.**

Will the plan always pay up to the maximum benefits per coverage year?

No. How much the plan pays depends on the type and amount of the health care you receive. Some types of charges may have limits that are reached before the overall maximum they are a part of is reached. This means that the plan may no longer pay for certain types of charges you continue to have, even though the overall maximum benefit has not been reached. Please read the benefits chart in the Colorado Health Benefit Plan Description Form carefully to understand what types of charges may be limited before the overall maximums in question are reached.

How does this limited benefits insurance plan differ from a traditional major medical health plan?

There are important differences in what the plan will pay and what the premium costs. Both types of plans cover many types of services and supplies. However, this limited benefits insurance plan has a lower maximum benefit and places limits on how much it will pay for categories of services or supplies. Once you have used up the overall maximums or limits on specific benefits, the plan will not pay any more. And unlike most major medical plans, this limited benefits insurance plan does not have catastrophic coverage or a limit on your out-of-pocket expenses. This means that you may have large out-of-pocket costs if you have a serious or chronic medical condition. Because traditional major medical health plans provide more coverage, they cost more.

What will I pay up front when I go to a healthcare provider?

A preferred doctor, hospital or other healthcare provider may require you to pay charges for which you are responsible in advance. This could include your copay, deductible, percentage of charges the plan does not pay (coinsurance), charges for services excluded under the plan, and charges in excess of your coverage limits. A non-preferred provider may require that you pay all charges in advance, and it would be up to you to submit a claim for reimbursement for any charges the plan may pay.

What are my rights for childbirth?

Under the Newborns' and Mothers' Health Protection Act (NMHPA), your plan will treat your hospital stay for the first 48 hours after a vaginal delivery (or 96 hours after cesarean section) as **medically necessary**. Your plan's overall benefit maximum, limits and deductibles will determine how much the plan will pay. The state in which you live, you work, or your plan was underwritten may have additional mandated rights regarding childbirth. Please refer to the plan documents.

What are my rights for reconstructive surgery after a mastectomy?

Under the Women's Health and Cancer Rights Act, your plan will consider as **medically necessary** post-mastectomy reconstruction of the same breast, or reconstruction of the other breast to achieve symmetry, prostheses, and treatment of physical complications of all stages of mastectomy including lymphedema. Your plan's overall benefit maximum, limits and deductibles will determine how much the plan will pay. The state in which you live, you work, or your plan was underwritten may have additional mandated rights regarding a mastectomy. Please refer to the plan documents.

What if I don't understand something I've read here, or have more questions?

Please call us. We want you to understand these benefits before you decide to enroll. You may reach one of our Customer Service representatives Monday through Friday, 8 a.m. to 8 p.m. Eastern Time, by calling toll free **1-888-772-9682**. We're here to answer questions before and after you enroll.

THIS LIMITED HEALTH BENEFITS PLAN DOES NOT PROVIDE COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC OR LIMITED BENEFITS POLICY AND IS NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS PLAN IS NOT DESIGNED TO COVER THE COSTS OF SERIOUS OR CHRONIC ILLNESS. IT CONTAINS SPECIFIC DOLLAR LIMITS THAT WILL BE PAID FOR MEDICAL SERVICES WHICH MAY NOT BE EXCEEDED. IF THE COST OF SERVICES EXCEEDS THOSE LIMITS, THE BENEFICIARY AND NOT THE INSURER IS RESPONSIBLE FOR PAYMENT OF THE EXCESS AMOUNTS. THE SPECIFIC DOLLAR LIMITS ARE DESCRIBED IN THIS BENEFITS SUMMARY.

ATTENTION MASSACHUSETTS RESIDENTS: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL (1-877-623-6765) or visit the Connector website (www.mahealthconnector.org). THIS HEALTH PLAN, ALONE, DOES NOT MEET MINIMUM CREDITABLE COVERAGE STANDARDS. If you have questions about this notice, you may contact the Division of Insurance by calling 617-521-7794 or visiting its website at www.mass.gov/doi.

Colorado law requires carriers to make available a **Colorado Health Benefit Plan Description Form**, which is intended to facilitate comparison of health plans. The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular plan or who has selected the plan as a finalist from which the ultimate selection will be made. The carrier also must provide the form, upon oral or written request, within three (3) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier.

This material is for information only and is not an offer or invitation to contract. Insurance plans contain exclusions and limitations. 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. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Discount programs provide access to discounted prices and are not insured benefits. Information is believed to be accurate as of the production date; however, it is subject to change.

Insurance plans are underwritten by Aetna Life Insurance Company. Plans are administered by Strategic Resource Company (SRC). Aetna Affordable Health Choices[®] is a registered service mark of Aetna Inc.

For OK residents only, policy forms issued include GR-9/GR-9N and GR-29/GR-29N.

The Affordable Care Act prohibits health plans from applying arbitrary dollar limits for coverage for key benefits. This year, if a plan applies a dollar limit on the coverage it provides for key benefits in a year, that limit must be at least \$750,000.

Your health insurance coverage, offered by Aetna Life Insurance Company, does not meet the minimum standards required by the Affordable Care Act described above. Instead, it has the following annual limits:

Medical Coverage Limits

Most this plan will pay per coverage year for:

Doctors' office visits	5 visits
Emergency room visits	\$1,000
Hospital services other than daily room charge	\$1,000
Hospital daily room charge and Inpatient Professional Services	\$10,000
Diagnostic & surgical and other outpatient services & supplies	\$400
Wellness visits	\$100

Most this plan will pay per month for prescriptions \$50

In order to apply the lower limits described above, your health plan requested a waiver of the requirement that coverage for key benefits be at least \$750,000 this year. That waiver was granted by the U.S. Department of Health and Human Services based on your health plan's representation that providing \$750,000 in coverage for key benefits this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. This waiver is valid for one year.

If the lower limits are a concern, there may be other options for health care coverage available to you and your family members. For more information, go to: www.HealthCare.gov.

If you have any questions or concerns about this notice, please contact SRC, an Aetna company, at 1-888-772-9682.

Some states offer a Consumer Assistance Program to help you better understand your health coverage options. For more information, please go to:
www.HealthCare.gov/news/factsheets/capgrants_states.html

Colorado Health Benefit Plan Description Form

Aetna Life Insurance Company

Name of Carrier

Aetna Affordable Health Choices[®] limited benefits insurance plan

- Basic Net -

Name of Plan

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Preferred Provider Plan
2. OUT-OF-NETWORK CARE COVERED?¹	Yes; patient pays more for such out-of-network care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout the state of Colorado. The plan is also available to eligible members outside of Colorado.

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

	IN-NETWORK	OUT-OF-NETWORK
4. DEDUCTIBLE TYPE²	Coverage Year Deductible ^{2A}	Coverage Year Deductible ^{2A}
4A. INPATIENT HOSPITAL DEDUCTIBLE a) Individual ^{2B} b) Family ^{2C}	a) Individual - \$250 b) Family - 2 individual deductibles per family	a) Individual - \$250 b) Family - 2 individual deductibles per family
5. OUT-OF-POCKET ANNUAL MAXIMUM³ a) Individual b) Family c) Is deductible included in the out-of-pocket maximum?	No out-of-pocket maximum.	No out-of-pocket maximum.

6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	<p>No Lifetime maximum. Inpatient maximum \$10,000 per coverage year.</p> <p>There is a \$1,000 limit on hospital-billed charges other than room and board per coverage year.</p> <p><i>Once this limit is reached, this benefit will no longer pay many hospital billed-charges. The plan will continue to pay for room and board and Inpatient Professional Services until the maximum benefit per coverage year is reached.</i></p>	<p>No Lifetime maximum. Inpatient maximum \$10,000 per coverage year.</p> <p>There is a \$1,000 limit on hospital-billed charges other than room and board per coverage year.</p> <p><i>Once this limit is reached, this benefit will no longer pay many hospital billed-charges. The plan will continue to pay for room and board and Inpatient Professional Services until the maximum benefit per coverage year is reached.</i></p>
7A. COVERED PROVIDERS	<p>See provider directory for complete list.</p>	<p>See provider directory for complete list.</p>
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	<p>Yes.</p>	<p>Not applicable.</p>
8. MEDICAL OFFICE VISITS⁴ a) Primary Care Providers b) Specialists	<p>a) Covered at 100% after a \$10 per visit copay not subject to deductible; limit of 5 visits per coverage year.</p> <p>b) Covered at 100% after a \$10 per visit copay not subject to deductible; limit of 5 visits per coverage year.</p>	<p>a) Covered at 80% after \$10 deductible; limit of 5 visits per coverage year.</p> <p>b) Covered at 80% after \$10 deductible; limit of 5 visits per coverage year.</p>
9. PREVENTIVE CARE a) Children's services b) Adults' services	<p>a) Covered at 100% after a \$15 per visit copay not subject to the deductible; up to \$100 per coverage year.</p> <p>b) Covered at 100% after a \$15 per visit copay not subject to the deductible; up to \$100 per coverage year.</p>	<p>a) Covered at 50%; up to \$100 per coverage year.</p> <p>b) Covered at 50%; up to \$100 per coverage year.</p>
10. MATERNITY a) Prenatal care b) Delivery & inpatient well baby care⁵	<p>a) Covered as Medical Office Visits (for outpatient services).</p> <p>b) Covered as Inpatient Hospital charges at 80%.</p>	<p>a) Covered as Medical Office Visits (for outpatient services).</p> <p>b) Covered as Inpatient Hospital charges at 60%.</p>

11. PRESCRIPTION DRUGS⁶ Level of coverage and restrictions on prescriptions	Covered at 100% with ID card after a \$10 copay for generic drugs and a \$20 copay for brand drugs; up to \$50 per month.	Covered at 50% with ID card; up to \$50 per month. Member pays full cost and submits claim for reimbursement.
12. INPATIENT HOSPITAL	Covered at 80%.	Covered at 60%.
13. OUTPATIENT/ AMBULATORY SURGERY	Covered at 100% after a \$15 per visit copay up to \$400 per coverage year.	Covered at 80% after a \$15 deductible per visit up to \$400 per coverage year.
14. DIAGNOSTICS a) Laboratory & x-ray b) MRI, nuclear medicine, and other high-tech services	Covered at 100% after a \$15 per visit copay up to \$400 per coverage year.	Covered at 80% after a \$15 deductible per visit up to \$400 per coverage year.
15. EMERGENCY CARE^{7,8}	Covered at 100% after a \$100 per coverage year deductible; up to \$1,000 per coverage year.	Covered at 100% after a \$100 per coverage year deductible; up to \$1,000 per coverage year.
16. AMBULANCE	Covered as Emergency Care if treated as Outpatient. Covered at 80% if admitted to hospital and treated as Inpatient.	Covered as Emergency Care if treated as Outpatient. Covered at 60% if admitted to hospital and treated as Inpatient.
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	Not covered.	Not covered.
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE⁹	Covered at 100% after a \$15 per visit copay up to \$400 or 5 visits per coverage year, whichever is used up first, if treated as Outpatient. Covered at 80% if admitted to hospital and treated as Inpatient.	Covered at 80% after a \$15 per visit copay up to \$400 or 5 visits per coverage year, whichever is used up first, if treated as Outpatient. Covered at 60% if admitted to hospital and treated as Inpatient.
19. OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care	a) Covered at 80%. b) Covered at 100% after a \$15 per visit copay up to \$400 or 5 visits per coverage year, whichever is used up first.	a) Covered at 60%. b) Covered at 80% after a \$15 per visit copay up to \$400 or 5 visits per coverage year, whichever is used up first.
20. ALCOHOL & SUBSTANCE ABUSE	Inpatient covered at 80%.	Inpatient covered at 60%.
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	Covered at 100% after a \$15 per visit copay up to \$400 per coverage year.	Covered at 80% after a \$15 deductible per visit up to \$400 per coverage year.
22. DURABLE MEDICAL EQUIPMENT	Not covered.	Not covered.
23. OXYGEN	Covered as Outpatient.	Covered as Outpatient.
24. ORGAN TRANSPLANTS	Covered at 80%.	Covered at 60%.

25. HOME HEALTH CARE	Covered at 100% after a \$10 per visit copay not subject to deductible; limit of 5 visits per coverage year.	Covered at 80% after \$10 deductible; limit of 5 visits per coverage year.
26. HOSPICE CARE	Covered at 100% after a \$10 per visit copay not subject to deductible; limit of 5 visits per coverage year.	Covered at 80% after \$10 deductible; limit of 5 visits per coverage year.
27. SKILLED NURSING FACILITY CARE	Covered at 80%.	Covered at 60%.
28. DENTAL CARE	Covered for dental care and treatment that is required because of an injury and rendered within 6 months of that injury.	Covered for dental care and treatment that is required because of an injury and rendered within 6 months of that injury.
29. VISION CARE	None.	None.
30. CHIROPRACTIC CARE	Covered at 100% after a \$15 per visit copay up to \$400 per coverage year.	Covered at 80% after a \$15 deductible per visit up to \$400 per coverage year.
31. SIGNIFICANT ADDITIONAL COVERED SERVICES		
ROUTINE MAMMOGRAPHY a) WOMEN AGE 35 - 39 b) WOMEN AGE 40 AND OLDER	a) One baseline mammogram per year. b) One mammogram per year.	a) One baseline mammogram per year. b) One mammogram per year.
DIGITAL RECTAL EXAM AND ROUTINE PROSTATE CANCER SCREENING FOR MEN AGE 40 OR OLDER	One exam and screening per year.	One exam and screening per year.

PART C: LIMITATIONS AND EXCLUSIONS

<p>32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED ¹⁰</p>	<p>For the first 365 days after an insured person enrolls, the plan will not pay for medical expenses for pre-existing conditions. The plan will reduce the pre-existing condition period by the number of days of "prior creditable coverage" as of the enrollment date. "Creditable coverage" means prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act of 1996. The pre-existing condition exclusion does not apply to pregnancy or to members under 19 years of age including a newborn child or a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.</p>
<p>33. EXCLUSIONARY RIDERS Can an individual's specific, pre-existing condition be entirely excluded from the policy?</p>	<p>No</p>
<p>34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?</p>	<p>Pre-existing conditions are those conditions for which the insured person received diagnosis, care or treatment within 180 days before that person enrolled in the plan.</p>
<p>35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?</p>	<p>Exclusions vary by policy. List of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g., employer). Review them to see if a service or treatment you may need is excluded from the policy.</p>

PART D: USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	No
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	No	No
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	Yes	Yes
39. What is the main customer service number?	1-888-772-9682	
40. Whom do I write/call if I have a complaint or want to file a grievance?¹¹	1-888-772-9682	
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	1-888-772-9682 to file a complaint, to file an appeal to a denied claim, or to obtain an external review request form.	
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	AMA110022380; large group	
43. Does the plan have a binding arbitration clause?	No	

Endnotes

¹ “Network” refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don’t (i.e., go out-of-network). If you live in an area that does not have a preferred health care provider, you will be considered out-of-area and receive benefits for eligible expenses as if you were using a preferred provider. Please note that if you travel to an area that has a preferred health care provider but use a non-preferred health care provider, you will not be eligible for preferred provider benefits. However, if you have a life-threatening medical emergency and use a non-preferred provider, you can call member services within two business days of the medical emergency treatment and your claim for the covered expenses will be treated as if presented by a preferred provider. Call member services Monday through Friday between 8 a.m. and 8 p.m. ET, at **1-888-772-9682**.

² “Deductible Type” indicates whether the deductible period is “Calendar Year” (January 1 through December 31) or “Benefit Year” (i.e., based on a benefit year beginning on the policy’s anniversary date) or if the deductible is based on other requirements such as a “Per Accident or Injury” or “Per Confinement”.

^{2a} “Deductible” means the amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year or benefit year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that are subject to deductible should be noted in boxes 8 through 31.

^{2b} “Individual” means the deductible amount you and each individual covered by a non-HSA qualified policy will have to pay for allowable covered expenses before the carrier will cover those expenses. “Single” means the deductible amount you will have to pay for allowable covered expenses under an HSA-qualified health plan when you are the only individual covered by the plan.

^{2c} “Family” is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified policy and it may be an aggregated amount (e.g., “\$3,000 per family member”) or specified as the number of individual deductibles that must be met (e.g., “3 deductibles per family”). “Non-single” is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any covered expenses are paid.

³ “Out-of-pocket maximum” means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductibles or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy. Expenses that are applied toward the out-of-pocket maximum should be noted in boxes 8 through 31.

⁴ Medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically-based mental illness.

⁵ Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together; there are not separate copayments.

⁶ Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

⁷ “Emergency care” means all services delivered in an emergency care facility that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.

⁸ Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after-hours care, then urgent care copayments apply.

⁹ “Biologically based mental illnesses” means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

¹⁰ Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

¹¹ Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

This is to provide notice as required under the federal law (the Women’s Health and Cancer Rights Act, effective October 21, 1998).

Under this health plan, coverage will be provided to a member who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy for:

1. reconstruction of the breast on which a mastectomy has been performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. prostheses; and
4. treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

Exclusions and limitations

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on the state mandates or the plan design or rider(s) purchased by your employer.

- All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents;
- Charges related to any eye surgery mainly to correct refractive errors;
- Cosmetic surgery, including breast reduction;
- Custodial care;
- Dental care and X-rays;
- Donor egg retrieval;
- Experimental and investigational procedures;
- Hearing aids;
- Immunizations for travel or work;
- Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents;
- Nonmedically necessary services or supplies;
- Orthotics;
- Over-the-counter medications and supplies;
- Reversal of sterilization;
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling;
- Special duty nursing.

Disclaimers

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

Some benefits are subject to limitations or visit maximums. Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. When the member utilizes a nonpreferred provider, Member must obtain the precertification. Precertification requirements may vary. Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available under plans with an open formulary or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary. They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after enrollment) are not covered, and medical exceptions are not available for them. While this information is believed to be accurate as of the print date, it is subject to change.

Plans are provided by Aetna Life Insurance Company.

Plans are administered by Strategic Resource Company (SRC), an Aetna Company.

**Attachment
Cancer Screening Coverage**

Colorado Health Benefit Plan Description Form Addendum

Aetna Life Insurance Company

Name of Carrier

Aetna Affordable Health Choices® limited medical benefits plan

Name of Plan

Breast Cancer Screening:

- Age 35 through 39, one baseline mammography
- Age 40 and older, one routine mammogram every year

Prostate Cancer screening:

- Age 40 through 49, one screening per year which will include a prostate specific antigen (PSA) blood test and a digital rectal examination; for **Members** who are at an increased risk of developing prostate cancer as determined by **Member's Physician**.
- Age 50 and older, one screening every year which will include a prostate specific antigen (PSA) blood test and a digital rectal examination.

Cervical Cancer screening:

- Routine gynecological examinations, including Pap smears, for routine care.

Colorectal Cancer screening:

Members aged 50 years and older

- Sigmoidoscopy (considered medically necessary every 5 years for persons at average risk); or
- Double contrast barium enema (DCBE) (considered medically necessary every 5 years for persons at average risk); or
- Colonoscopy (considered medically necessary every 10 years for persons at average risk).
- In addition, Aetna considers screening with annual immunohistochemical or guaiac-based fecal occult blood testing (FOBT), either alone or in conjunction with sigmoidoscopy, medically necessary preventive services for members beginning at age 50 years.

High-Risk Screening:

- A first-degree relative (sibling, parent, child) who has had colorectal cancer or an adenomatous polyposis (screening is considered medically necessary beginning at age 40 years);
- Family history of familial adenomatous polyposis (screening is considered medically necessary beginning at puberty);
- Family history of hereditary non-polyposis colorectal cancer (HNPCC) (screening is considered medically necessary beginning at age 20 years).
- Aetna considers annual FOBT, alone or in conjunction with sigmoidoscopy, a medically necessary preventive service for screening of colorectal cancer.



Aetna Affordable Health Choices[®]

Enrollment/Change Request

Association of National Park Rangers
801101

Insurance plans are underwritten by Aetna Life Insurance Company and administered by Strategic Resource Company (SRC - An Aetna Company).

Instructions: Read and fill out the Enrollment/Change Request (all pages). Make a copy for yourself. Return the original to ANPR.
IF YOU ARE NOT CHANGING YOUR EXISTING COVERAGE, YOU DO NOT NEED TO COMPLETE THIS ENROLLMENT/CHANGE REQUEST.

INFORMATION ABOUT YOU

Complete all information.

Print your name (first, middle initial, last)		Social Security Number	Date of birth (MM/DD/YYYY)	
Home address	Apartment number	City	State	Zip code
Home phone () ()	Work phone () ()	Email address	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Primary language spoken (Idioma principal)

ACTION YOU WANT TO TAKE

Check the box next to the action you want to take.

I am not currently enrolled and I want to...	<input type="checkbox"/> Enroll in the coverage choices selected below. <input type="checkbox"/> Decline this opportunity to participate.
I am currently enrolled and I want to...	<input type="checkbox"/> Make changes to my current coverage choices (add, increase, drop, decrease) as selected below. All of my other coverage choices will remain the same as previously elected. (If outside of an open enrollment, see "Making Changes Outside of an Open Enrollment.") <input type="checkbox"/> Update my personal and/or my dependent and/or beneficiary information. <input type="checkbox"/> Drop all of my current coverage choices.

Your payroll deductions will be taken after taxes are taken.

YOUR COVERAGE CHOICES

Check () the box for the level of coverage you want.

Coverage type	Coverage level	Monthly cost	
Medical	<input type="checkbox"/> No Medical		
	<input type="checkbox"/> Yourself only.....	\$ 99.46	
	<input type="checkbox"/> Yourself plus one.....	\$ 248.48	
	<input type="checkbox"/> Yourself and family.....	\$ 355.94	
	Group limited benefit medical coverage is not available if you live and work in New Hampshire.		
Hospital Indemnity	<input type="checkbox"/> No Hospital Indemnity		
	<input type="checkbox"/> Yourself only.....	\$ 14.96	
	<input type="checkbox"/> Yourself plus one.....	\$ 29.92	
	<input type="checkbox"/> Yourself and family.....	\$ 44.88	
	Coverage is not available if you live and work in New Hampshire.		
Vision	<input type="checkbox"/> No Vision		
	<input type="checkbox"/> Yourself only.....	\$ 4.36	
	<input type="checkbox"/> Yourself plus one.....	\$ 7.40	
	<input type="checkbox"/> Yourself and family.....	\$ 10.40	
	Coverage is not available if you live and work in New Hampshire.		
Dental	<input type="checkbox"/> No Dental		
	<input type="checkbox"/> Yourself only.....	\$ 19.28	
	<input type="checkbox"/> Yourself plus one.....	\$ 38.60	
	<input type="checkbox"/> Yourself and family.....	\$ 63.72	
	Short Term Disability (STD)	<input type="checkbox"/> No Short Term Disability	
<input type="checkbox"/> Yourself only.....		\$ 15.20	
Coverage is not available if you work in California, Hawaii, New Jersey, New York, Rhode Island, and Puerto Rico.			
Term Life Insurance		<input type="checkbox"/> No Term Life	
		<input type="checkbox"/> Yourself only.....	\$ 6.68
	<input type="checkbox"/> Yourself and family.....	\$ 8.16	
Please name your beneficiary. Beneficiary _____ Relationship: _____ Social Security Number _____			

YOUR AUTHORIZATION

You must sign and date this Enrollment/Change Request for all new enrollments or coverage changes.

I represent that all information supplied in this Enrollment/Change Request is true and complete to the best of my knowledge and/or belief. I have read and agree to the Conditions of Enrollment on the reverse side of this Enrollment/Change Request.

Your signature _____ Today's date (MM/DD/YYYY) _____

FOR ANPR'S USE ONLY

This section is to be completed by your employer.

Employee ID	Hire date (MM/DD/YYYY)	Pay type	Total deduction (\$)	Effective date (MM/DD/YYYY)
Location or site code	Authorized signature	Title	Today's date (MM/DD/YYYY)	

INFORMATION ABOUT YOU Repeat your name and Social Security number here.

Print your name (first, middle initial, last)

Social Security Number

INFORMATION ABOUT YOUR DEPENDENTS List the dependents for whom you are adding/changing/removing coverage.

If you have more dependents, write down their information on a separate sheet and attach it to this Enrollment/Change Request.

<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Print dependent's name (first, middle initial, last)	Social Security Number		
	Sex <input type="checkbox"/> Male / <input type="checkbox"/> Female	Date of birth	Enrolled in: <input type="checkbox"/> Medical / <input type="checkbox"/> Hospital Indemnity / <input type="checkbox"/> Vision / <input type="checkbox"/> Dental / <input type="checkbox"/> Term Life	
	Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (Specify): _____			
	Address (if different than yours)	City	State	Zip code
<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Print dependent's name (first, middle initial, last)	Social Security Number		
	Sex <input type="checkbox"/> Male / <input type="checkbox"/> Female	Date of birth	Enrolled in: <input type="checkbox"/> Medical / <input type="checkbox"/> Hospital Indemnity / <input type="checkbox"/> Vision / <input type="checkbox"/> Dental / <input type="checkbox"/> Term Life	
	Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (Specify): _____			
	Address (if different than yours)	City	State	Zip code
<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Print dependent's name (first, middle initial, last)	Social Security Number		
	Sex <input type="checkbox"/> Male / <input type="checkbox"/> Female	Date of birth	Enrolled in: <input type="checkbox"/> Medical / <input type="checkbox"/> Hospital Indemnity / <input type="checkbox"/> Vision / <input type="checkbox"/> Dental / <input type="checkbox"/> Term Life	
	Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (Specify): _____			
	Address (if different than yours)	City	State	Zip code

MAKING CHANGES OUTSIDE OF AN OPEN ENROLLMENT Please read below to see if you are able to make changes to your coverage.

You can add to or increase your coverage during the plan year only if you have a **Qualifying Life Event (QLE)**. If your deductions are taken after taxes, you may drop or decrease coverage at any time. QLEs fall under one of these two categories:

Loss of Other Coverage (LOC): If you previously declined health coverage because you or your dependents were already covered under another health plan and you or your dependents have lost that other coverage, you may be able to enroll yourself and your dependents. If you had a recent LOC, go to the list on the right and check the box next to your LOC and supply the date of the LOC.

Family Status Change (FSC): Whether you are currently enrolled or previously declined coverage, you may be able to add or increase coverage when you experience certain FSC events. If you had a recent FSC, go to the list on the right and check the box next to your FSC and supply the date of the FSC.

Next, complete the rest of this Enrollment/Change Request. When finished, make a copy and submit it to your employer with your documentation attached. You must submit this Enrollment/Change Request, together with documentation, to your employer within 30 days of the LOC/FSC.

Loss of Other Coverage (LOC):

- Divorce, legal separation or death
- Termination of employment of a dependent
- Reduction of a dependent's hours
- Termination of your or your dependents' COBRA rights
- Loss of employer's contribution to spouse's coverage
- Dependent child losing eligibility as a dependent
- Other loss of coverage

Family Status Change (FSC):

- Divorce, legal separation or death
- Marriage
- Birth or adoption of a dependent
- Other

Date of LOC or FSC (mm/dd/yyyy)

CONDITIONS OF ENROLLMENT Applicant acknowledgments and agreements

On behalf of myself and the dependents listed on this Enrollment/Change Request, I agree to or with the following:

1. I acknowledge that by enrolling in an Aetna plan coverage is underwritten by Aetna Life Insurance Company (referred to as "Aetna") 151 Farmington Avenue, Hartford, CT 06156 and administered by Strategic Resource Company (SRC, an Aetna company), 221 Dawson Road, Columbia, SC 29223.
2. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage.
3. **For life and disability coverages:** I understand that the effective date of insurance for myself or for any of my dependents, if applicable, is subject to my being actively at work on that date and that the effective date of insurance for any of my dependents is also subject to the dependent health condition requirements of the benefit plan. I understand that, in the event I fail to sign this form within 30 days of the effective date of eligibility or that for any reason Aetna does not receive notice of the Enrollment/Change Request within a reasonable time following the date I was eligible to enroll or change my coverage, my and my dependents' eligibility, if applicable, may be affected. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until Aetna gives its written consent.
4. I understand and agree that this Enrollment/Change Request may be transmitted to Aetna or its agent by my employer or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers") to give Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this Enrollment/Change Request, including those involving mental health, substance abuse and HIV/AIDS. I further authorize Aetna to use such information and to disclose such information to affiliates, providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse and competent adult dependents and I have obtained their consent to those terms. I understand that this authorization is provided under state law and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.
5. The plan documents will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
6. I understand and agree that with the exception of Aetna Rx Home Delivery[®], all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.
7. **Misrepresentation:**

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention Arkansas Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

Attention Maryland Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Rhode Island Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

Attention Vermont Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Attention West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Important Disclosure Information

For Aetna Affordable Health Choices® Plans

Plan of Benefits

Your plan of benefits will be determined by your plan sponsor and underwritten by the Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, Connecticut, 06156. The benefits and main points of the Group Policy for persons covered under your plans of benefits will be set forth in the Booklet-Certificate which will be provided to you at a later date.

Cost Sharing

You are responsible for any copayments, coinsurance and deductibles for covered services. These obligations are paid directly to the provider or facility at the time the service is rendered. Copayment, coinsurance and deductible amounts are listed in your benefits summary and plan documents.

How Aetna Compensates Your Health Care Provider

All the physicians are independent practicing physicians that are neither employed nor exclusively contracted with Aetna. Individual physicians and other providers are in the network by either directly contracting with Aetna* and/or affiliating with a group or organization that contract with us.

Participating providers in our network are compensated in various ways:

- Per individual service or case (fee for service at contracted rates).
- Per hospital day (per diem contracted rates).

Advance Directives

An advance directive is a legal document that states your wishes for medical care. It can help doctors and family members determine your medical treatment if, for some reason, you can't make decisions about it yourself.

There are three types of advance directives:

- Living will - spells out the type and extent of care you want to receive.
- Durable power of attorney - appoints someone you trust to make medical decisions for you.

- Do-not-resuscitate order - states that you don't want to be given CPR if your heart stops or if you stop breathing.

You can create an advance directive in several ways:

- Get an advance medical directive form from a health care professional. Certain laws require health care facilities that receive Medicare and Medicaid funds to ask all patients at the time they are admitted if they have an advance directive. You don't need an advance directive to receive care. But we are required by law to give you the chance to create one.
- Ask for an advance directive 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.

Advanced Directives and Do Not Resuscitate Orders. American Academy of Family Physicians, March 2005. (Available at <http://familydoctor.org/003.xml?printxml>)

After-Hours Care

You may call your doctor's office 24 hours a day, 7 days a week if you have medical questions or concerns. You may also consider visiting participating Urgent Care facilities.

Behavioral Health Provider Safety Data Available

For information regarding our Behavioral Health provider network safety data, please go to www.aetna.com and review the quality and patient safety links posted: www.aetna.com/docfind/quality.html#jcaho. You may select the quality checks link for details regarding our providers' safety reports.

Claims Payment for Nonparticipating Providers and Use of Claims Software

If your plan includes coverage for out-of-network services, and you obtain coverage under this portion of your plan, you should be aware that Aetna generally determines payment for an out-of-network provider by referring to (i) commercially available data reflecting the customary

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

amount paid to most providers for a given service in that geographic area or (ii) by accessing other contractual arrangements. If such data is not commercially available, our determination may be based upon our own data or other sources. Aetna may also use computer software (including ClaimCheck®) and other tools to take into account factors such as the complexity, amount of time needed and manner of billing. You may be responsible for any charges Aetna determines are not covered under your plan.

Technology Review

Aetna reviews new medical technologies, behavioral health procedures, pharmaceuticals and devices to determine which ones should be covered by our plans. And we even look at new uses for existing technologies to see if they have potential. To review these innovations, we may:

- Study medical research and scientific evidence on the safety and effectiveness of medical technologies.
- Consider position statements and clinical practice guidelines from medical and government groups, including the federal Agency for Health care Research and Quality.
- Seek input from relevant specialists and experts in the technology.
- Determine whether the technologies are experimental or investigational.

You can find out more on new tests and treatments in our Clinical Policy Bulletins. You can find the bulletins at www.aetna.com, under the "Members and Consumers" menu.

Medically Necessary

"Medically necessary" means that the service or supply is provided by a physician or other health care provider exercising prudent clinical judgment for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that provision of the service or supply is:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate in accordance with generally accepted standards of medical practice in terms of type, frequency, extent, site and duration, and considered effective for the illness, injury or disease;
- Not primarily for the convenience of you, or for the physician or other health care provider; and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the illness, injury or disease.

For these purposes "**generally accepted standards of medical practice**" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Clinical Policy Bulletins

Aetna's CPBs describe Aetna's policy determinations of whether certain services or supplies are medically necessary or experimental or investigational, based upon a review of currently available clinical information. Clinical determinations in connection with individual coverage decisions are made on a case-by-case basis consistent with applicable policies.

Aetna's CPBs do not constitute medical advice. Treating providers are solely responsible for medical advice and for your treatment. You should discuss any CPB related to your coverage or condition with your treating provider.

While Aetna's CPBs are developed to assist in administering plan benefits, they do not constitute a description of plan benefits. Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. You and your providers will need to consult the benefit plan to determine if there are any exclusions or other benefit limitations applicable to this service or supply.

Filing a Complaint or Appeal

Aetna is committed to addressing your coverage issues, complaints and problems. If you have a coverage issue or other problem, call Member Services at the toll free number on your ID card. If Member Services is unable to resolve your issue to your satisfaction, it will be forwarded to the appropriate department for handling.

If you are dissatisfied with the outcome of your initial contact, you may file an appeal. Your appeal will be decided in accordance with the procedures applicable to your plan and applicable state law. Refer to your plan documents for further details regarding your plan's appeal procedure.

About Coverage Decisions

Sometimes we receive claims for services that may not be covered by your health benefits plan or that aren't in line with the terms of your plan. It can be confusing - even to your doctors. Our job is to make coverage decisions based on your specific benefits plan. If a claim is denied, we'll send you a letter to let you know. If you don't agree you can file an appeal. To file an appeal, follow the directions in the letter that explains that your claim was denied. Our

appeals decisions will be based on your plan provisions and any state and federal laws or regulations that apply to your plan. You can learn more about the appeal procedures for your plan from your plan documents.

External Review

Aetna established an external review process to give you the opportunity of requesting an objective and timely independent review of certain coverage denials. Once the applicable appeal process has been exhausted, you may request an external review of the decision if the coverage denial, for which you would be financially responsible, involves more than \$500* and is based on lack of medical necessity or on the experimental or investigational nature of the proposed service or supply. Standards may vary by state, if a state-mandated external review process exists and applies to your plan.

An Independent Review Organization (IRO) will assign the case to a physician reviewer with appropriate expertise in the area in question. After all necessary information is submitted, an external review generally will be decided within 30 calendar days of the request.

Expedited reviews are available when your physician certifies that a delay in service would jeopardize your health. Once the review is complete, the plan will abide by the decision of the external reviewer. The cost for the review will be borne by Aetna (except where state law requires you to pay a filing fee as part of the state mandated program).

Certain states mandate external review of additional benefit or service issues; some may require a filing fee. In addition, certain states mandate the use of their own external review process for medical necessity and experimental/ investigational coverage decisions. For further details regarding your plan's appeal process and the availability of an external review process, call the Member Services toll-free number on your ID card. You may obtain an external review request form from Member Services. You also may call your state insurance or health department or consult their website for additional information regarding state mandated external review procedures.

Member Rights & Responsibilities

You have the right to receive a copy of our Member Rights and Responsibilities Statement. This information is available to you online at www.aetna.com/about/MemberRights/. You can also obtain a printed copy by contacting Member Services at the number on your ID card.

www.aetna.com

Member Services

To request additional information regarding benefits, copayments or other charges, or how to file a claim, complaint or appeal, or if you have any other questions, you can contact Member Services at the toll-free number on your ID card.

Interpreter/Hearing Impaired

When you require assistance from an SRC representative, call us during regular business hours at the number on your ID card. Our representatives can:

- Answer benefits questions
- Find care outside your area
- Advise you on how to file complaints and appeals
- Connect you to behavioral health services (if included in your plan)
- Find specific health information

Multilingual hotline - 1-888-982-3862

(140 languages are available.)

You must ask for an interpreter.)

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

Quality Management Programs

Call Aetna to learn about the specific quality efforts we have under way in your local area. Ask Member Services for the phone number of your regional Quality Management office. If you would like information about Aetna Behavioral Health's Quality Management Program, ask Member Services for the phone number of your Care Management Center Quality Management office.

Privacy Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to your physical or mental health or condition, the provision of health care to you, or payment for the provision of health care to you. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify you.

When necessary or appropriate for your care or treatment, the operation of our health plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the

services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. Participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claims payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health claims analysis and reporting; health services research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health plans. To the extent permitted by law, we use and disclose personal information as provided above without your consent. However, we recognize that you may not want to receive unsolicited marketing materials unrelated to your health benefits. We do not disclose personal information for these marketing purposes unless you consent. We also have policies addressing circumstances in which you are unable to give consent.

To obtain a hard copy of our Notice of Privacy Practices which describes in greater detail our practices concerning use and disclosure of personal information, please write to Strategic Resource Company (SRC), Post Office Box 14079, Lexington, KY 40512-4079.

You can also visit our Internet site at www.aetna.com/docfind/custom/aaahc/. You can link directly to the Notice of Privacy Practices by Plan Type, by selecting the "Privacy Notices" link at the bottom of the page, and selecting the link that corresponds to your specific plan.

State Variations

In some states, Aetna provides additional consumer disclosures in documents also posted on our website at www.aetna.com/docfind/custom/aahc/.

Georgia

Members can call 1-888-772-9682 (toll-free) to confirm that the preferred provider in question is in the network and/or accepting new patients.

Members have direct access to the participating primary Ob/Gyn provider of their choice and do not need a referral from their PCP for a routine well-woman exam, including a Pap smear when appropriate and an unlimited number of visits for gynecologic problems and follow-up care.

Members also have direct access to the participating dermatologist provider of their choice and do not need a referral from their primary care physicians to access dermatologic benefits covered under their health plan.

A summary of any agreement or contract between Aetna and any health care provider will be made available upon request by calling the Member Services telephone number on your ID card. The summary will not include financial agreements as to actual rates, reimbursements, charges, or fees negotiated by Aetna and the provider. The summary will include a category or type of compensation paid by Aetna to each class of health care provider under contract with Aetna.

Consumer Choice Option

The Consumer Choice Option is available for Georgia residents enrolled in certain Aetna managed care plans. Under this benefit option, with certain restrictions required by law and an additional monthly premium cost, members of certain Aetna managed care plans may nominate an out-of-network provider to provide covered services for themselves and their covered family members. Your benefits and any applicable copayments will be the same as for in-network providers. The out-of-network provider must agree to accept the Aetna compensation, to adhere to the plan's quality assurance requirements, and to meet all other reasonable criteria required by the plan of its in-network participating providers. It is possible the provider you nominate will not agree to participate.

This option is available for an increased premium in addition to the premium you would otherwise pay. Your increased premium responsibility will vary depending on whether you have a single plan or family coverage, and on the type of insurance, riders, and coverage. Exact pricing and any additional information can be obtained by calling 1-888-772-9682. Please have your Aetna member ID card available when you call.

www.aetna.com

Hawaii

Informed Consent

Members have the right to be fully informed prior to 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; and
- discuss all risks, benefits, and consequences of treatment and non-treatment.

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

Insurance Division Telephone Number:

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

Illinois

While every provider listed in the provider directory contracts with Aetna to provide primary care services, not every provider listed will be accepting new patients. Although Aetna has identified those providers who were not accepting patients as known to Aetna at the time the Provider Directory was created, the status of the physician's practice may have changed. For the most current information regarding the status of any physician's practice, please contact either the selected physician or call Member Services at the toll-free number on your ID card.

Illinois law requires health plans to provide the following information annually to enrollees and to prospective enrollees upon request: a complete list of participating health care providers in the health care plan's service area and 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 pre-certification 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; and
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.

Additionally, upon written request, the health plan will provide enrollees with 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 the insured is entitled in the particular health plan which is covering or being offered to such person;
2. A description of any limitations, exceptions or exclusions to coverage in the health benefit plan, including prior authorization policies, restricted drug formularies or other provisions which restrict access to covered services or items by the insured;
3. A listing of the plan 's participating providers, their business addresses and telephone numbers, their availability, and any limitation on an insured's choice of provider;
4. Notification in advance of any changes in the health benefit plan which either reduces the coverage or benefits or increases the cost to such person; and

5. A description of the grievance and appeal procedures available under the health benefit plan and an insured's rights regarding termination, disenrollment, non-renewal or cancellation of coverage.

Kentucky

Any provider who meets our enrollment criteria and who is willing to meet the terms and conditions for participation has a right to become a participating provider in our network.

Emergency Medical Condition Definition

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.

Louisiana

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

Maryland

Behavioral Health Care Expense Form

To obtain a copy of the Behavioral Health Care Expense Form, please call the number located on the back of your ID card.

Michigan

Contact the Michigan Department of Consumer and Industry Services at 1-517-373-0220 to verify participating providers' licenses or to access information on formal complaints and disciplinary actions filed or taken against participating providers.

Upon request, pursuant to Michigan law, the following information can be supplied to you:

1. date of provider certification by applicable nationally recognized board or other organization;
2. names of licensed facilities where providers have privileges;

3. prior authorization requirements and limitations including medication formulary restrictions;
4. information about financial relationships between providers and the health plan.

Intractable Pain Coverage

Aetna provides benefits for the evaluation and treatment of intractable pain when it is determined to be medically necessary and otherwise eligible by Aetna. Intractable pain means "a pain state in which the cause of the pain cannot be removed or otherwise treated and which, in the generally accepted practice of allopathic or osteopathic medicine, no relief of the cause of the pain or cure of the cause of the pain is possible or none has been found after reasonable efforts, including, but not limited to, evaluation by the attending physician and by one or more other physicians specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain."

To obtain this and further information on the health plan, you may call Member Services at 1-888-772-9682.

Texas

Please refer to the plan design for a brief description of the services and benefits covered under your particular plan, as well as those services and benefits that are excluded. After enrollment, you can refer to your plan documents for a more complete description of your covered services and benefits and the exclusions under your plan. For information on whether a specific service is covered or excluded, please contact Member Services at the toll-free number on your ID card.

Health Insurance Portability and Accountability Act

The following information is provided to inform you of certain provisions contained in the Group Health Plan, and related procedures that may be utilized by you in accordance with Federal law.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. To request special enrollment or obtain more information, contact your benefits administrator.

Request for Certificate of Creditable Coverage

If you are a member of an insured plan sponsor or a member of a self insured plan sponsor who have contracted with us to provide Certificates of Prior Health Coverage, you have the option to request a certificate.

This applies to you if you are a terminated member, or are a member who is currently active but who would like a certificate to verify your status. As a terminated member, you can request a certificate for up to 24 months following the date of your termination. As an active member can request a certificate at any time. To request a Certificate of Prior Health Coverage, please contact Member Services at the telephone number on your ID card.

If you need this material translated into another language, please call Member Services at 1-888-772-9682. Si usted necesita este documento en otro idioma, por favor llame a Servicios al Miembro al 1-888-772-9682.