

Important Disclosure Information - Texas

Type of Coverage:

Your plan contains preferred provider benefits and is underwritten or administered by Aetna Life Insurance Company.

Additional Information:

You may call 1-888-982-3862 or write to Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, CT 06156, if you wish to obtain additional information about Aetna* or your plan. Additional information concerning your coverage, Aetna coverage plan bulletins, and Aetna's network of participating providers can be accessed via the internet at: www.aetna.com.

Preferred and Nonpreferred Providers:

This plan offers two levels of benefits: preferred and nonpreferred. You can choose which level of benefits you would like to utilize at the time health care services are needed.

The preferred level of benefits utilizes a network of contracted providers who have agreed to negotiated rates, utilization and quality management programs. You have complete access to any participating provider, including specialists, without a referral and do not need to designate a primary care physician. If you utilize participating providers you will incur a lower out-of-pocket cost for medical care because of Aetna's negotiated rates, modest copays and lower deductibles.

You may decide to utilize an out-of-network provider at the nonpreferred benefit level. This would result in a lower level of benefits and shifts the responsibility for preauthorization and claims filing to you. If seeking care from nonparticipating providers you must usually meet the plan deductible before coinsurance takes effect. Charges are subject to reasonable and customary limits.

Covered Services and Benefits:

Your plan covers the same wide range of services regardless of whether you use a participating provider or a nonparticipating provider. Standard covered services include:

- Physician office visits.
- Hospitalization and surgery.

- Diagnostic testing.
- Emergency care.
- Home health care.
- Maternity and newborn care.
- Mental health and substance abuse care.
- Durable medical equipment.
- Prescription drugs.
- Preventative care.

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>)

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

Emergency Care Services and Benefits:

Your plan covers emergency care services provided by preferred or nonpreferred providers. In the event of a medical emergency, you should seek treatment at the nearest emergency facility or call the local emergency hotline (e.g. 911).

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.

Out of Area Services and Benefits:

Your plan provides coverage for eligible expenses you incur when you travel out of the service area. The plan pays nonpreferred benefits for health care services incurred by nonpreferred providers.

Your Financial Responsibility:

You are responsible for paying copayments and deductibles for preferred benefits. You are responsible for coinsurance, deductibles for nonpreferred benefits. Additionally, you may be financially responsible for other ineligible expenses incurred by a nonpreferred provider such as charges above the reasonable and customary limit.

Exclusions and limitations:

The plan does not cover all health care expenses and it contains exclusions and limitations. You must refer to your plan documents to determine what expenses are covered and to what extent.

Continuity of Care:

In the event a preferred provider terminates from the plan while you are under going an active course of treatment with that provider, Aetna will cooperate with your physician and approve a transition period for you to either complete the plan of treatment or transition to another preferred provider.

Complaints, Appeals and External Review:

This Complaint Appeal and External Review process may not apply if your plan is self-funded. Contact your Benefits Administrator if you have any questions.

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 or e-mail us from your secure member website, Aetna Navigator. Click on "Contact Us" after you log in. You can also contact Member Services

through the Internet at: www.aetna.com. 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.

Service Area:

Aetna has preferred providers located in every county in the state of Texas.

Additional Important Information Plan of Benefits:

Your health benefit plan will be determined by your plan sponsor, even though the plan itself is underwritten or administered by Aetna Life Insurance Company, located at 151 Farmington Avenue, Hartford, CT 06156 Aetna's main toll free telephone number is 1-888-982-3862. Covered services include most types of treatment. However, the health benefit plan does exclude and/or include limits on coverage for some services, including but not limited to, cosmetic surgery and experimental procedures. In addition, in order to be covered, all services, including the location (type of facility), duration and costs of services, must be medically necessary as defined in the provisions below and as determined by Aetna. The information that follows provides a general overview regarding Aetna health benefit plans. For a complete description of the benefits available to you, including procedures, exclusions and limitations, refer to your specific plan documents, which may include the Group Agreement, Group Insurance Certificate, Group Policy and any applicable riders and amendments included with your health benefit plan.

Utilization Review/Patient Management:

Aetna has developed a patient management program to assist in determining what health care services are covered under the health plan and the extent of such coverage. The program assists you in receiving appropriate healthcare and maximizing coverage for those healthcare services. You can avoid receiving an unexpected bill with a simple call to Aetna's Member Services team. You can find out if your preventive care service, diagnostic test or other treatment is a covered benefit - **before you receive care** - just by calling the toll-free number on your ID card. In certain cases, Aetna reviews your request to be sure the service or supply is consistent with established guidelines and is included or a covered benefit under your plan. We call this "utilization management review."

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

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

Where such use is appropriate, our Utilization Review/Patient Management staff uses nationally recognized guidelines and resources, such as The Milliman Care Guidelines[®] to guide the preauthorization, concurrent review and retrospective review processes. To the extent certain Utilization Review/Patient Management functions are delegated to IDs, IPAs or other provider groups ("Delegates"), such Delegates utilize criteria that they deem appropriate. Utilization Review/Patient Management policies may be modified to comply with applicable state law.

Only medical directors make decisions denying coverage for services for reasons of medical necessity. Coverage denial letters for such decisions delineate any unmet criteria, standards and guidelines, and inform the provider and you of the appeal process.

For more information concerning utilization management, you may request a free copy of the criteria we use to make specific coverage decisions by contacting Member Services.

You may also visit

www.aetna.com/about/cov_det_policies.html to find our Clinical Policy Bulletins and some utilization review policies. Doctors or health care professionals who have questions about your coverage can write or call our Patient Management department. The address and phone number are on your ID card.

Prescription Drugs:

If your plan covers outpatient prescription drugs, your plan may include a preferred drug list (also known as a "drug formulary"). The preferred drug list includes a list of prescription drugs that, depending on your prescription drug benefits plan, are covered on a preferred basis. Many drugs, including many of those listed on the preferred drug list, are subject to rebate arrangements between Aetna and the manufacturer of the drugs. Such rebates are not reflected in and do not reduce the amount you pay for a prescription drug. In addition, in circumstances where your prescription plan utilizes copayments or coinsurance calculated on a percentage basis or a deductible, your costs may be higher for a preferred drug than they would be for a nonpreferred drug. For information regarding how medications are reviewed and selected for the preferred drug list, please refer to Aetna's website at www.aetna.com or the Aetna Preferred Drug (Formulary) Guide. Printed Preferred Drug Guide information will be provided, upon request or if applicable, annually for current members and upon enrollment for new members. Additional information can be obtained by calling Member Services at the toll-free number listed on your ID card. The medications listed on the preferred drug list are subject to change in accordance with applicable state law.

Your prescription drug benefit is generally not limited to drugs listed on the preferred drug list. Medications that are not listed on the preferred drug list (nonpreferred or nonformulary drugs) may be covered subject to the limits and exclusions set forth in your plan documents.

Covered nonformulary prescription drugs may be subject to higher copayments or coinsurance under some benefit plans. Some prescription drug benefit plans may exclude from coverage certain nonformulary drugs that are not listed on the preferred drug list. If it is medically necessary for you to use such drugs, their physicians (or pharmacist in the case of antibiotics and analgesics) may contact Aetna to request coverage as a medical exception. Check your plan documents for details.

In addition, certain drugs may require preauthorization or step-therapy before they will be covered under some prescription drug benefit plans. Step-therapy is a different form of preauthorization which requires a trial of one or more "prerequisite therapy" medications before a "step therapy" medication will be covered. If it is medically necessary for you to use a medication subject to these requirements, your physician can request coverage of such drug as a medical exception. In addition, some benefit plans include a mandatory generic drug cost-sharing requirement. In these plans, you may be required to pay the difference in cost between a covered brand name drug and its generic equivalent in addition to your copayment if you obtain the brand-name drug. Nonprescription drugs

and drugs in the Limitations and Exclusions section of the plan documents (received and/or available upon enrollment) are not covered, and medical exceptions are not available for them.

Depending on the plan selected, new prescription drugs not yet reviewed for possible addition to the preferred drug list are either available at the highest copay under plans with an "open" formulary, or excluded from coverage unless a medical exception is obtained under plans that use a "closed" formulary. These new drugs may also be subject to preauthorization or step-therapy.

You should consult with your treating physician(s) regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding terms, conditions and limitations of coverage. If you use the mail order prescription program of Aetna Rx Home Delivery, LLC, you will be acquiring these prescriptions through an affiliate of Aetna. Aetna's negotiated charge with Aetna Rx Home Delivery® may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail-order pharmacy services. For these purposes, Aetna Rx Home Delivery's cost of purchasing drugs takes into account discounts, credits and other amounts that it may receive from wholesalers, manufacturers, suppliers and distributors.

If you use the Aetna Specialty PharmacySM specialty drug program, you will be acquiring these prescriptions through Aetna Specialty Pharmacy, LLC, which is jointly owned by Aetna and Priority Healthcare, Inc. Aetna's negotiated charge with Aetna Specialty Pharmacy may be higher than Aetna Specialty Pharmacy's cost of purchasing drugs and providing specialty pharmacy services. For these purposes, Aetna Specialty Pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that it may receive from wholesalers, manufacturers, suppliers and distributors.

Updates to the Drug Formulary:

You can obtain formulary information from the Internet at www.aetna.com/formulary/, or by calling your Member Services toll-free number.

Behavioral Health Network:

Behavioral health care services are managed by Aetna, who is responsible for, in part, making initial coverage determinations and coordinating referrals to Aetna's provider network. As with other coverage determinations, you may appeal adverse behavioral health care coverage determinations in accordance with the terms of your health plan.

The type of behavioral health benefits available to you depends upon the terms of your health plan.

If your health plan includes behavioral health services, you may be covered for mental health conditions and/or drug and alcohol abuse services. You can determine the type of behavioral health coverage available under the terms of your plan by calling the Aetna Member Services number listed on your ID card.

If you have an emergency, call 911 or your local emergency hotline, if available. For routine services, access covered behavioral health services available under your health plan by the following methods:

- Call the toll-free Behavioral Health number (where applicable) listed on your ID card or, if no number is listed, call the Member Services number listed on your ID card for the appropriate information.
- Where required by your plan, call your PCP for a referral to the designated behavioral health provider group.
- When applicable, an employee assistance or student assistance professional may refer you to your designated behavioral health provider group.

You can access most outpatient therapy services without a referral or pre-authorization. However, you should first consult with Member Services to confirm that any such outpatient therapy services do not require a referral or pre-authorization.

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: <http://www.aetna.com/docfind/quality.htm> | #jcaho. You may select the quality checks link for details regarding our providers' safety reports.

Behavioral Health Prevention Programs:

Aetna Behavioral Health offers two prevention programs for our members: Perinatal Depression Education, Screening and Treatment Referral Program also known as "Mom's to Babies Depression Program" and Identification and Referral of Adolescent Members Diagnosed With Depression Who Also Have Co-morbid Substance Abuse Needs. For more information on either of these prevention programs and how to use the programs, ask Member Services for the phone number of your local Care Management Center.

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 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 one 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 Healthcare 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.

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 <http://www.aetna.com/about/MemberRights/>. You can also obtain a print copy by contacting Member Services at the number on your ID card.

Interpreter/Hearing Impaired:

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

- Answer benefits questions
- Help you get referrals
- 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
- Provide information on our Quality Management program, which evaluates the ongoing quality of our services

Spanish-speaking hotline - 1-800-533-6615

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.

Member Services:

To file a complaint or an appeal, for additional information regarding copayments and other charges, information regarding benefits, to obtain copies of plan documents, information regarding how to file a claim or for any other question, you can contact Member Services at the toll-free number on your ID card, or e-mail us from your secure member website, Aetna Navigator at www.aetna.com. Click on "Contact Us" after you log in.

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 Aetna's Legal Support Services Department at 151 Farmington Avenue, W121, Hartford, CT 06156. You can also visit our Internet site at www.aetna.com. You can link directly to the Notice of Privacy Practices by selecting the "Privacy Notices" link at the bottom of the page.

Health Insurance Portability and Accountability Act

Note: 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 the back of your ID card.

Consumer Choice health benefit plans issued pursuant to the Texas Consumer Choice of Benefits Health Insurance Plan Act do not include all state mandated health insurance benefits. Benefits provided under a Consumer Choice Benefit plan are provided at a reduced level from what is mandated or are excluded completely from the plan. The following list of covered benefits may not be available under a Consumer Choice health benefit plan.

Notice of Certain Mandatory Benefits

This notice is to advise you of certain coverage and/or benefits provided by your contract with Aetna. If you have any questions concerning this notice, please call us at the Member Services number on the back of your ID card, or write us at the following address: **Aetna Patient Management P.O. Box 569440 Dallas, Texas 75356-9440**

Coverage of Tests for Detection of Human Papillomavirus and Cervical Cancer

Coverage is provided, for each woman enrolled in the plan who is 18 years of age or older, for expenses incurred for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Coverage required under this section includes at a minimum a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus

Form Number LHL391 Human Papillomavirus and Cervical Cancer Screening

Coverage for Tests for Detection of Colorectal Cancer

Benefits are provided, for each person enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include the covered person's choice of:

- (a) a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years, or
- (b) a colonoscopy performed every 10 years.

Form Number 1467 Colorectal Cancer Screening

Prostate Cancer Screening

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include a:

- (a) Physical examination for the detection of prostate cancer
- (b) Prostate-specific antigen test for each covered male who is at least:
 - (1) 50 years of age
 - (2) 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

Form Number 258 Prostate

Inpatient Stay Following Birth of a Child

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

- (a) 48 hours following an uncomplicated vaginal delivery.
- (b) 96 hours following an uncomplicated delivery by cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to (a) give birth in a hospital or other health care facility or (b) remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for post delivery care. Post delivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a physician, registered nurse or other appropriate licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

Because we provide in-home post delivery care, we are not required to provide the minimum number of hours outlined above unless (a) the mother's or child's physician determines the inpatient care is medically necessary or (b) the mother requests the inpatient stay.

Prohibitions: We may not (a) modify the terms of this coverage based on any covered person requesting less than the minimum coverage required; (b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required; (c) refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians; (d) reduce payments or reimbursements below the usual and customary rate; or (f) penalize a physician for recommending inpatient care for the mother or the newborn child.

Form Number 102 Maternity

Breast Reconstruction

Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including:

- (a) All stages of the reconstruction of the breast on which mastectomy has been performed.
- (b) Surgery and reconstruction of the other breast to achieve a symmetrical appearance.
- (c) Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

The coverage and/or benefits must be provided in a manner to be appropriate in consultation with the covered person and the attending physician.

Prohibitions: We may not (a) offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above; (b) condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or (c) reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits shown above.

Form Number 1764 Reconstructive Surgery After Mastectomy - Enrollment

Mastectomy or Lymph Node Dissection Minimum Inpatient Stay

If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:

- (a) 48 hours following a mastectomy, and
- (b) 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the individual receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not (a) deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours; (b) provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours; (c) reduce or limit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a covered person to receive the minimum inpatient hours; or (d) provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

Form Number 349 Mastectomy

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

Health insurance plans are underwritten by Aetna Life Insurance Company. For self-funded accounts, benefits coverage is offered by your employer, with administrative services only provided by Aetna Life Insurance Company. 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. Information subject to change.

The NCQA Accreditation Seal is a recognized symbol of quality. The seal, located on the front cover of your provider directory, signifies that your plan has earned this accreditation for service and clinical quality that meets or exceeds the NCQA's rigorous requirements for consumer protection and quality improvement. The number of stars on the seal represents the accreditation level the plan has achieved.

Providers who have been duly recognized by the NCQA Recognition Programs are annotated in the provider listings section of this directory. Providers, in all settings, achieve recognition by submitting data that demonstrates they are providing quality care. The program constantly assesses key measures that were carefully defined and tested for their relationship to improved care, therefore, NCQA provider recognition is subject to change. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. For up-to-date information, please visit our DocFind[®] directory at www.aetna.com or, if applicable, visit the NCQA's new top level recognition listing at <http://web.ncqa.org/tabid/58/Default.aspx>.