

Important Disclosure Information

For Managed Choice®, Elect Choice®, Open Choice® and Aetna Open Access® Plans.

State mandates do not apply to self-funded plans governed by ERISA. If you are unsure if your plan is self-funded and/or governed by ERISA, see your benefits administrator.

Plan Benefits

Your plan of benefits is determined by your plan sponsor. The plan your employer chooses is underwritten or administered by Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, CT 06156, 1-888-982-3862. Covered services include most types of treatment provided by primary care physicians, specialists and hospitals. However, a health plan excludes and/or includes 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 below and as determined by Aetna. The information that follows provides general information regarding Aetna health plans. For a complete description of the benefits available to you, including procedures to follow, exclusions and limitations, refer to your specific plan documents, which may include the Booklet-certificate, Group Agreement, Group Insurance Certificate, Group Policy and any applicable riders and amendments to your plan.

Member Cost Sharing

Cost sharing refers to the portion of medical services that you pay out of your own pocket. Refer to your plan documents to see which of the following cost-sharing provisions apply to your plan:

- Copay – This may be a flat fee that you pay directly to the health care provider at the time of service.
- Coinsurance – This is a percentage of the fees that you must pay toward the cost of some covered medical expenses. Your health care provider will bill you for this amount.
- Calendar Year Deductible – The amount of covered medical expenses you pay each calendar year before benefits are paid. There is a calendar-year deductible that applies to each person.
- Inpatient Hospital Deductible – The amount of covered inpatient hospital expenses you pay for each hospital confinement before benefits are paid. This deductible is *in addition to* any other copayments or deductibles under your plan.
- Emergency Room Deductible – The amount of covered hospital emergency room expenses you pay each year before benefits are paid. A separate hospital emergency room deductible applies to each visit by a person to a hospital emergency room unless the person is admitted to the hospital as an inpatient within 24 hours after a visit to a hospital emergency room.

The applicability and amount of each copay and deductible listed above will be determined by your plan sponsor and described in your plan documents.

Have a Student Plan?

If you have a Student Accident and Sickness plan please visit www.aetnastudenthealth.com for questions or call Aetna Student Health at the toll-free number on your ID card for more information. For appeals, please forward your request to Chickering Claims Administrators, Inc., P.O. Box 15717, Boston, MA 02215-0014. Fully insured student health insurance plans are underwritten by Aetna Life Insurance Company (ALIC) and administered by Chickering Claims Administrators, Inc. (CCA). Self-insured plans are funded by the applicable school, with claims administration services provided by Chickering Claims Administrators, Inc. Aetna Student Health is the brand name for products and services provided by ALIC and CCA.

* The Chickering Group refers to an internal business unit of Chickering Claims Administrators, Inc. The Student Plan is underwritten by Aetna Life Insurance Company and administered by Chickering Claims Administrators, Inc.

Your Primary Care Physician

Check your plan documents to see if your plan requires you to select a primary care physician (PCP). If a PCP is required, you must choose a doctor from the Aetna network. You can look up network doctors in a printed Aetna Physician Directory, or visit our DocFind® directory at www.aetna.com. If you do not have Internet access and would like a printed directory, please contact Member Services at the toll-free number on your ID card and request a copy.

You may choose a different PCP for each member of your family. When you enroll, indicate the name of the PCP you have chosen on your enrollment form. Or, call Member Services after you enroll to tell us your selection. The name of your PCP will appear on your Aetna ID card. You may change your selected PCP at any time. If you change your PCP, you will receive a new ID card.

Your PCP can provide primary health care services as well as coordinate your overall care. You should consult your PCP when you are sick or injured to help determine the care that is needed. If your plan requires referrals, your PCP should issue a referral to a participating specialist or facility for certain services. (See Referral Policy for details.)

Referral Policy

Check your plan documents to see if your plan requires PCP referrals for specialty care. If referrals are required, you must see your PCP first before visiting a specialist or other outpatient provider for nonemergency or nonurgent care. Your PCP will issue a referral for the services needed.

If you do not get a referral when a referral is required, you may have to pay the bill yourself, or the service will be treated as nonpreferred if your plan includes out-of-network benefits. Some services may also require prior approval by us. See the Precertification section and your plan documents for details.

The following points are important to remember regarding referrals.

- The referral is how your PCP arranges for you to be covered at the in-network benefit level for necessary, appropriate specialty care and follow-up treatment.

- You should discuss the referral with your PCP to understand what specialist services are being recommended and why.
- If the specialist recommends any additional treatments or tests beyond those referred by the PCP, you may need to get another referral from your PCP before receiving the services.
- Except in emergencies, all inpatient hospital services require a prior referral from your PCP and prior authorization by Aetna.
- Referrals are valid for one year as long as you remain an eligible member of the plan; the first visit must be within 90 days of referral issue date.
- In plans without out-of-network benefits, coverage for services from nonparticipating providers requires prior authorization by Aetna in addition to a special nonparticipating referral from the PCP. When properly authorized, these services are fully covered, less the applicable cost sharing.
- The referral (and a precertification, if required) provides that, except for applicable cost sharing (that is, copays, coinsurance and/or deductibles), you will not have to pay the charges for covered expenses, as long as the individual seeking care is a member at the time the services are provided.

Direct Access Ob/Gyn Program

This program allows female members to visit without a referral any participating obstetrician or gynecologist for a routine breast exam, mammogram and a Pap smear, and for obstetric or gynecologic problems. Obstetricians and gynecologists may also refer a woman directly to other participating providers for covered obstetric or gynecologic services. All health plan preauthorization and coordination requirements also apply. If your Ob/Gyn is part of an Independent Practice Association (IPA), a Physician Medical Group (PMG), an Integrated Delivery System (IDS) or a similar organization, your care must be coordinated through the IPA, the PMG or similar organization and that organization may have different referral policies.

Product	PCP Required?	Referrals Required?	Precertification Required?
Open Choice	No	No	Yes
Managed Choice	Yes	Yes	Yes
Aetna Open Access Managed Choice	Encouraged	No	Yes
Elect Choice	Yes	Yes	Yes
Aetna Open Access Elect Choice	Encouraged	N/A	Yes

Precertification

Some health care services, like hospitalization and certain outpatient surgery, require “precertification.” This means the service must be approved by Aetna before it will be covered under the plan. Check your plan documents for a complete list of services that require this approval. When reviewing a precertification request, we will verify your eligibility and make sure the service is a covered expense under your plan. We also check the cost-effectiveness of the service and we may communicate with your doctor if necessary. If you qualify, we may enroll you in one of our case management programs and have a nurse call to make sure you understand your upcoming procedure.

When you visit a doctor, hospital or other provider that participates in the Aetna network, someone at the provider’s office will contact Aetna on your behalf to get the approval.

If your plan allows you to go outside the Aetna network of providers, you will have to get that approval yourself. In this case, it is your responsibility to make sure the service is precertified, so be sure to talk to your doctor about it. If you do not get proper authorization for out-of-network services, you may have to pay for the service yourself.

You cannot request precertification after the service is performed. To precertify services, call the number shown on your Aetna ID card. In plans that do not have out-of-network benefits, coverage for services from nonparticipating providers requires prior authorization by Aetna in addition to a special nonparticipating referral from the PCP. When properly authorized, these services are fully covered, less the applicable cost sharing.

Health Care Provider Network

All hospitals may not be considered Aetna participating providers for all the services that you need. Your physician can contact Aetna to identify a participating facility for your specific needs. Certain PCPs are affiliated with IDSs, IPAs or other provider groups. If you select one of these PCPs you will generally be referred to specialists and hospitals within that system, association or group (“organization”). However, if your medical needs extend beyond the scope of the affiliated providers, you may request coverage for services provided by Aetna network providers that are not affiliated with the organization. In order to be covered, services provided by network providers that are not affiliated with the organization may require prior authorization from Aetna and/or the IDS or other provider groups. You should note that other health care providers (e.g. specialists) may be affiliated with other providers through organizations.

For up-to-date information about how to locate inpatient and outpatient services, partial hospitalization and other behavioral health care services, please visit our DocFind

directory at www.aetna.com. If you do not have Internet access and would like a printed provider directory, please contact Member Services at the toll-free number on your Aetna ID card and request a copy.

Advance Directives

There are three types of advance directives:

- Durable power of attorney – appoints someone you trust to make medical decisions for you.
- Living will – spells out the type and extent of care you want to receive.
- Do-not-resuscitate order – states that you don’t want to be given CPR if your heart stops or be intubated 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.
- If you are not satisfied with the way Aetna handles advance directives, you can file a complaint with your Medicare State Certification Agency. Visit www.medicare.gov for information on specific state agencies or call 1-800-MEDICARE (1-800-633-4227) (TTY/TDD: 1-877-486-2048).

Source: American Academy of Family Physicians. *Advanced Directives and Do Not Resuscitate Orders*. January 2009. Available at <http://familydoctor.org/003.xml?printxml>. Accessed February 20, 2009.

Transplants and Other Complex Conditions

Our National Medical Excellence Program® and other specialty programs help you access covered services for transplants and certain other complex medical conditions at participating facilities experienced in performing these services. Depending on the terms of your plan of benefits, you may be limited to only those facilities participating in these programs when needing a transplant or other complex condition covered.

Note: There are exceptions depending on state requirements.

Emergency Care

If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world. An emergency medical condition is one manifesting itself by acute symptoms of sufficient severity such that a prudent person, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child. Whether you are in or out of an Aetna service area, we simply ask that you follow the guidelines below when you believe you need emergency care.

- Call the local emergency hotline (ex. 911) or go to the nearest emergency facility. If a delay would not be detrimental to your health, call your doctor or PCP. Notify your doctor or PCP as soon as possible after receiving treatment.
- If you are admitted to an inpatient facility, you or a family member or friend on your behalf should notify your doctor, PCP or Aetna as soon as possible.

What to Do Outside Your Aetna Service Area

If you are traveling outside your Aetna service area or if you are a student who is away at school, you are covered for emergency and urgently needed care. Urgent care may be obtained from a private practice physician, a walk-in clinic, an urgent care center or an emergency facility. Certain conditions, such as bleeding, severe vomiting or fever, are considered "urgent care" outside your Aetna service area and are covered in any of the above settings.

If, after reviewing information submitted to us by the provider that supplied care, the nature of the urgent or emergency problem does not qualify for coverage, we may ask you for more information to qualify the coverage. We will send you an Emergency Room Notification Report to complete, or a Member Services representative can take this information by telephone.

After-Hours Care

You may call your provider'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. See your plan documents for cost-sharing provisions for urgent care services.

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 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 to your pharmacy for a prescription drug. In addition, in circumstances where your prescription plan utilizes copayments or coinsurance calculated on a percentage of the cost of a drug or a deductible, it is possible for your cost to be higher for a preferred drug than it would for a nonpreferred drug. For information regarding how medications are reviewed and selected for the preferred drug list, please refer to 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. For more information, call Member Services at the toll-free number 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, your physician, you or your authorized representative (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 precertification or step therapy before they will be covered under some prescription drug benefit plans. Step therapy is a different form of precertification that 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 prior to completing the step therapy, your physician, you or your authorized representative 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 precertification or step therapy.

Ask your treating physician(s) 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 Aetna Rx Home Delivery® mail-order prescription program or the Aetna Specialty Pharmacy® specialty drug program, you will be acquiring these prescriptions through an affiliate of Aetna. Aetna Rx Home Delivery's and Aetna Specialty Pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts they may receive from wholesalers, manufacturers, suppliers and distributors. The negotiated charge with Aetna Rx Home Delivery, LLC. and Aetna Specialty Pharmacy may be higher than the cost of purchasing drugs and providing pharmacy services.

Updates to the Drug Formulary

For up-to-date formulary information, visit www.aetna.com/formulary/ or call Member Services at the toll-free number on your Aetna ID card. If you do not have Internet access, you may contact Member Services at the toll-free number on your ID card to find out how a specific drug is covered.

Behavioral Health Network

Behavioral health care services are managed by Aetna. As a result, Aetna is responsible for making initial coverage determinations and coordinating referrals to the Aetna 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 on the terms of your health plan and state law. If your health plan includes behavioral health services, you may be covered for mental health conditions and/or drug and alcohol abuse services, including inpatient and outpatient services, partial hospitalizations and other behavioral health services. You can determine the type of behavioral health coverage available under the terms of your plan and how to access services 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 preauthorization. However, you should first consult Member Services to confirm that any such outpatient therapy services do not require a referral or preauthorization.

Behavioral Health Provider Safety Data Available

For information about our Behavioral Health provider network safety data, visit www.aetna.com/docfind and select the "Get info on Patient Safety and Quality" link. If you do not have Internet access, you may call Member Services at the toll-free number shown on your Aetna ID card to request a printed copy of this information.

Behavioral Health Depression Prevention Programs

Aetna Behavioral Health offers two prevention programs for our members: Perinatal Depression Education, Screening and Treatment Referral Program, also known as Beginning Right® Depression Program, and Identification and Referral of Adolescent Members Diagnosed With Depression Who Also Have Comorbid 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.

How Aetna Pays In-Network Providers

All the providers in our network directory are independent. They are free to contract with other health plans. Providers join our network by signing contracts with us. Or they work for organizations that have contracts with us. We pay network providers in many different ways. Sometimes we pay a rate for a specific service and sometimes for an entire course of care (for example, a flat fee for a pregnancy without complications). In certain circumstances, some providers are paid a pre-paid amount per month per Aetna member (capitation). We may also provide additional incentives to reward physicians for delivering cost-effective quality care.

We pay some network hospitals by the day (per diem) and we pay others in a different way, such as a percentage of their standard billing rates. We encourage you to ask your providers how they are paid for their services.

How Aetna Pays Out-of-Network Providers

Some of our plans pay for services from providers who are not in our network. Many plans pay for services based on what is called the "reasonable," "usual and customary" or "prevailing" charge. Other plans pay based on our standard fees for care received from a network provider, or based on a percentage of Medicare's fees. **When we pay less than what your provider charges, your provider may require you to pay the difference. This is true even if you have reached your plan's out-of-pocket maximum.** Here is how we figure out what we will pay for each type of plan.

Prevailing Charge Plans

Step 1: We review the data.

We get information from Ingenix, which is owned by United HealthCare. Health plans send Ingenix copies of claims for services they received from providers. The claims include the date and place of the service, the procedure code, and the provider's charge. Ingenix combines this information into databases that show how much providers charge for just about any service in any zip code.

Step 2: We calculate the portion we pay.

For most of our health plans, we use the 80th percentile to calculate how much to pay for out-of-network services. Payment at the 80th percentile means 80 percent of charges in the database are the same or less for that service in a particular zip code.

If there are not enough charges (less than 9) in the databases for a service in a particular zip code, we may use "derived charge data" instead. "Derived charge data" is based on the charges for comparable procedures, multiplied by a factor that takes into account the relative complexity of the procedure that was performed. We also use derived charge data for our student health plans and Aetna Affordable Health Choices® plans.

We also may consider other factors to determine what to pay if a service is unusual or not performed often in your area. These factors can include:

- The complexity of the service
- The degree of skill needed
- The provider's specialty
- The prevailing charge in other areas
- Aetna's own data

Step 3: We refer to your health plan.

We pay our portion of the prevailing charge as listed in your health plan. You pay your portion (called "coinsurance") and any deductible.

For example, your out of network doctor charges \$120 for an office visit. Your plan covers 70 percent of the "reasonable," "usual and customary" or "prevailing" charge. Let's say the prevailing charge is \$100. And let's say you already met your deductible. Aetna would pay \$70. You would pay the other \$30. Your doctor may also bill you for the \$20 difference between the prevailing charge (\$100) and the billed charge (\$120). In this case, your doctor could bill you for a total of \$50.

The Prevailing Charge Databases

The New York State Attorney General (NYAG) investigated the conflicts of interest related to the ownership and use of Ingenix data. Under an agreement with the NYAG, UnitedHealth Group agreed to stop using the Ingenix databases when an independent database (not owned by a health insurer) is created. In a separate agreement with NYAG in January 2009, Aetna agreed to use this new database when it is ready. We also will work with the new database owner to create online tools to give you better information about the cost of your care when using providers outside our network.

Fee Schedule Plans

Step 1: We compare the provider's bill to our fee schedule and your health plan.

Your plan may say that we will pay the provider based on our fee schedule for network doctors, or a certain percentage of that fee schedule, or a certain percentage of what Medicare pays. For example, your plan may say we pay 125 percent of what we pay a network doctor for the same service.

Let's say you have your appendix removed. Our network rate for that surgery is \$1,600. We multiply \$1,600 by 125 percent to get \$2,000. We call this the "recognized" or "allowed" amount.

Step 2: We calculate the portion we pay.

Your plan also says that you must pay "coinsurance." This is your share of the "recognized" or "allowed" amount.

For example, your share may be 30 percent. In that case, we pay 70 percent of the \$2,000 allowed amount, which is \$1,400. You pay your provider your 30 percent coinsurance, which is \$600. Your provider may also ask you to pay the \$500 difference between the \$2,500 bill and the \$2,000 "recognized" or "allowed" amount. In this case, your provider could bill you \$1,100 in total.

Exceptions

Some "prevailing charge" plans set the prevailing charge at a different percentile. For some claims (like those from hospitals and outpatient centers) we may use other information and data sources to determine the charge.

And some of our plans pay based on a different kind of fee schedule. Also, for some non-participating providers we may pay based on other contractual arrangements.

Our provider claims codes and payment policies may also affect what we pay for a claim. Aetna may 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. The effects of these policies will be reflected in your Explanation of Benefits documents.

How Aetna Pays for Out-of-Network Behavioral Health Benefits

We negotiate rates with psychiatrists, psychologists, counselors and other appropriately licensed and credentialed behavioral health care providers to help you save money. We refer to these providers as being "in our network."

Technology Review

We review 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 review these innovations, we may:

- Study published 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. See Clinical Policy Bulletins below for more information.

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; and
- 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; and

- 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

Clinical Policy Bulletins (CPBs) describe our policy determinations of whether certain services or supplies are medically necessary or experimental or investigational, based on 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 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 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.

CPBs are regularly updated and are therefore subject to change. Aetna CPBs are available at www.aetna.com under "Members" and then "Health Coverage Information." If you do not have Internet access, please contact Member Services at the toll-free number on your ID card for information about specific Clinical Policy Bulletins.

Utilization Review/Patient Management

We have 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 health care and maximizing coverage for those health care services. You can avoid receiving an unexpected bill with a

simple call to Member Services. 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, we review your request to be sure the service or supply is consistent with established guidelines and is 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 precertification, concurrent review and retrospective review processes. To the extent certain Utilization Review/Patient Management functions are delegated to IDSs, 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 professionals 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.

Concurrent Review

Concurrent review is a review conducted while a patient is confined on an inpatient basis. The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members receiving inpatient services. All inpatient services extending beyond the initial certification period require concurrent review.

Discharge Planning

Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits that

may be utilized by you upon discharge from an inpatient stay.

Retrospective Record Review

Retrospective review is a review conducted after the patient has been discharged from the hospital or facility. The purpose of retrospective review is to analyze potential quality and utilization issues, initiate appropriate follow-up action based on quality or utilization issues, and review all appeals of inpatient concurrent review decisions for coverage of health care services. Our effort to manage the services provided to you includes the retrospective review of claims submitted for payment, and of medical records submitted for potential quality and utilization concerns.

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

We are 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 Aetna Navigator® member website. Click on “Contact Us” after you log on. You can also contact Member Services 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 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. 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

We 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 internal appeal process has been exhausted, you may request an external review of the decision for the coverage denial if: (a) you would be financially responsible for the cost of services; (b) the amount of the service(s) is more than \$500, and (c) 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, and several states have external review processes that may apply to your plan.

If a request meets the requirement for an external review, an Independent Review Organization (IRO) will assign the case to an external physician reviewer with appropriate expertise for an independent decision 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 a 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 or investigational coverage decisions. These state mandates may not apply to self-funded plans.

For details about your plan's appeal process and the availability of an external review process, call the Member Services toll-free number on your ID card or visit www.aetna.com to print an external review request form, or call the Member Services toll-free number on your ID card. You also may call your state insurance or health department or consult their websites 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 at www.aetna.com/about/MemberRights. You can also obtain a print copy by contacting Member Services at the number on your ID card.

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 email us from your secure

Aetna Navigator member website at www.aetna.com. Click on "Contact Us" after you log on.

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

Multilingual hotline – 1-888-982-3862 (140 languages are available. You must ask for an interpreter.)

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

TDD Member Services – 1-800-628-3323 (hearing impaired only)

Quality Management Programs

We have a comprehensive quality measurement and improvement strategy, and do not view it as an isolated, departmental function. Rather, we integrate quality management and metrics into all that we do. For details on our program, goals and our progress on meeting those goals, go to www.aetna.com/members/health_coverage/quality/quality.html. If you do not have Internet access and would like a hard copy of the information referenced here, please contact Member Services at the toll-free number on your ID card and request a copy.

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

www.aetna.com

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 request a printed 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 Legal Support Services Department
151 Farmington Avenue, W121
Hartford, CT 06156

You can also visit www.aetna.com and link directly to the Notice of Privacy Practices by selecting the "Privacy Notices" link at the bottom of the page.

Non-discrimination statement

Aetna does not discriminate in providing access to health care services on the basis of race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national origin. We are required to comply with Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, other laws applicable to recipients of federal funds, and all other applicable laws and rules.

Use of Race, Ethnicity and Language Data

Aetna members have the option to provide us with race/ethnicity and preferred language information. This information is voluntary and confidential. We collect this information to identify, research, develop, implement and/or enhance initiatives to improve health care access, delivery and outcomes for diverse members, and otherwise improve services to our members. We will maintain administrative, technical and physical safeguards to protect information concerning member race, ethnicity and language preference from inappropriate access, use or disclosure. This data will be collected, used or disclosed only in accordance with Aetna policies and applicable state and federal requirements. It is not used to determine eligibility, rating or claim payment.

For more information, please visit www.aetna.com. If you do not have Internet access and would like a hard copy of the information referenced here, please contact Member Services at the toll-free number on your ID card and request a copy.

State Variations

Note: State benefits mandates may not apply to self-insured plans. Contact Member Services with specific questions about your coverage. In some states, Aetna provides additional consumer disclosures in documents also posted on our website at www.aetna.com.

Colorado

To obtain reimbursement rates for nonparticipating providers, you may contact Member Services at the number listed on your ID card.

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.

The Colorado Consumer Protection Standards Act for the operation of Managed Care Plans ((S)10-16-704(9) of the Colorado Revised Statutes), requires a carrier to maintain an "access plan" for each managed care network that the carrier offers in Colorado. In general, an access plan lists hospitals, providers, referral procedures, grievance procedures, and emergency coverage provisions.

The law requires the carrier to make its access plans (except for certain confidential information, as specified in section 24-72-204 (3) of the Colorado Revised Statutes) available on its business premises and to provide them to any interested party upon request. To obtain additional information regarding our Colorado access plan(s), please call Member Services at the toll-free number listed on your ID card.

Enrolling in Aetna does not guarantee services by a particular provider in the physician directory. If you wish to be sure of receiving care from specific providers listed, you should contact those providers to be sure that they are accepting additional patients for Aetna. Also, we may add physicians on a periodic basis and will provide you with a listing of newly added doctors in your local area, if you request it.

The availability of any particular provider cannot be guaranteed for referred or in-network benefits, and provider network composition is subject to change without notice. In addition, not every provider listed in the directory will be accepting new patients. For the most current information, please contact the selected physician or Member Services at the toll-free number listed on your ID card.

COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFITS PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2-50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFITS PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW.

In accordance with Colorado law, Aetna has established open enrollment periods for guarantee issue basic or standard plan applications from business groups of one. The open enrollment period is a period of 31 days following the birth date of the person qualifying as a business group of one. Issuance of a basic health benefit plan and a standard health benefit plan is limited to such thirty-one day period. A copy of the applicant's driver's license or birth certificate must be provided as evidence of the applicant's birth date. In addition to the annual 31 day enrollment period, persons qualifying as business groups of one may apply within 31 days of the date of the following events: (1) the end of state or federal continuation coverage; (2) the person initially meets the business group of one definition requirements and whose birth date is more than 31 days after doing so; or (3) the person involuntarily loses other creditable coverage. (This event (3) does not apply in cases of failure to pay premium, fraud, or a voluntary decision on the part of the person to terminate other creditable coverage.

Renewability

This coverage is renewable at your option, except for the following reasons:

- Nonpayment of premiums
- Fraud or intentional misrepresentation of material fact on the part of the plan sponsor with respect to group health benefit plan coverage and the individual with respect to individual coverage
- Violation of participation or contribution rules
- The carrier elected to discontinue offering and nonrenew all of its individual, small group or large group plans delivered or issued for delivery in Colorado

- With respect to small group health plans, an employer is no longer actively engaged in the business in which it was engaged on the effective date of the plan
- For network plans, there are no longer any enrollees who reside or work in the service area
- If the employer's membership in a bona fide association ceases, but only if coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual

Provider Network

In Colorado, our complete network for the products listed on the cover of the provider directory include providers located in every county in the state.

To obtain reimbursement rates for nonparticipating providers, you may contact Member Services at the toll-free number on your Aetna ID card.

Connecticut

Religious Exemption

As permitted under Connecticut law, an insurer may issue to a religious employer a policy that excludes coverage for infertility treatment that is contrary to the religious employer's beliefs.

Some of these treatments may include:

- Ovulation induction (OI)
- Intrauterine insemination
- In-vitro fertilization (IVF)
- Embryo transfer
- Gamete intra-fallopian transfer (GIFT)
- Zygote intra-fallopian transfer (ZIFT)
- Low tubal ovum transfer
- Uterine embryo lavage

Delaware

Mandated Benefit - Scalp Hair Prosthesis:

Aetna will provide coverage for expenses for a scalp hair prosthesis worn for hair loss suffered as a result of alopecia areata, resulting from an autoimmune disease. The same limitations and guidelines that apply to other prosthesis as outlined in your Benefit Plan will apply but coverage for scalp hair prosthesis as a result of alopecia areata will not exceed \$500 per year.

For Female Members

For plans that require or encourage members to select a PCP, female members may choose a participating obstetrician/gynecologist (Ob/Gyn) as their PCP if:

- The Ob/Gyn meets the standards established by the plan for PCPs
- The Ob/Gyn requests that the plan make the Ob/Gyn available for designation as a PCP

- The Ob/Gyn agrees to accept the payment terms applicable under the Plan to PCPs for services other than Ob/Gyn services
- The Ob/Gyn agrees to abide by all other terms and conditions applicable to PCPs under the plan generally. If the female member does not choose a participating Ob/Gyn as her primary then the member must be permitted to visit the participating Ob/Gyn without referral for covered services. In such cases, the Ob/Gyn must consult with the PCP with respect to the care given and any follow up care, and the plan may require a visit to the PCP, if necessary, before the patient may be directed to another specialty provider, or for inpatient hospitalization or outpatient surgical procedures.

Delaware Insurance Department

You have the right to seek review of a claim denial through the Delaware Insurance Department. The Delaware Insurance Department also provides free informal mediation services, which are in addition to, but do not replace, your right to a review of the decision. You can contact the Delaware Insurance Department for information about claim denial review or mediation by calling the Consumer Services Division at 1-800-282-8611 or 302-739-4251. You may go to the Delaware Insurance Department at The Rodney Building, 841 Silver Lake Blvd., Dover, DE 19904 between the hours of 8:30 a.m. and 4:00 p.m. to personally discuss the review or mediation process.

All requests for review through procedures established by the Delaware Insurance Department must be filed within 60 days from the date you receive your decision notice; otherwise the decision will be final.

Complaints, Appeals and External Review

The processes that follow will apply for plans that require or encourage members to select a PCP. 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

Aetna is committed to addressing members' coverage issues, complaints and problems. If you are dissatisfied with the service you receive from the Plan or want to complain about a participating provider you must call or write Member Services at the toll-free number or address on your ID card. You can also contact Member Services through the Internet at www.aetna.com. Aetna will review and make a determination within 30 calendar days of receipt of the complaint, and provide you with a written response, unless additional information is needed that cannot be obtained within this time frame. The notice of the decision will tell you what you need to do to seek an additional review.

Filing an Appeal

If Aetna gives you notice of an adverse benefit determination, you may file an appeal. Verbal or written requests for an appeal must be communicated, mailed or delivered within 180 days following receipt of the notice of adverse determination. An adverse benefit determination is a denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a service or supply. Your appeal will be decided in accordance with the procedures outlined below.

Your appeal should include:

- Your name
- Your employer's name
- A copy of Aetna's notice of an Adverse Benefit Determination
- Your reasons for making the appeal
- Any other information you would like to have considered

Send in your appeal to Member Services at the address shown on your ID card or call in your appeal to Member Services using the toll-free telephone number shown on your ID card.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to Aetna.

You may also request the assistance of an Aetna employee to understand the appeal process. Such an employee will not have prior, direct involvement in your appeal.

Level One Appeal Based on the Service or Supply being Experimental, Cosmetic, or not Medically Necessary

A level one appeal of an adverse benefit determination shall be provided by a Medical Director or other physician not involved in making the adverse benefit determination. If the decision is provided verbally, a written decision shall be provided within five business days of the verbal notice.

- Urgent Care Claims (may include Concurrent Care Claim, Reduction or Termination): Aetna shall issue a decision within 36 hours of receipt of the request for an Appeal.
- Pre-Service Claims (may include Concurrent Care Claim, Reduction or Termination) and Post-Service Claims: Aetna shall issue a decision within 5 business days of receipt of the request for an Appeal. If you do not agree with such determination you have the right to file a second request for review within 60 days of receipt of the resolution letter.

Level One Appeal Not Based on the Service or Supply being Experimental, Cosmetic, or not Medically Necessary

A level one appeal of an adverse benefit determination shall be provided by Aetna personnel not involved in making the adverse benefit determination.

Urgent Care Claims

(May Include Concurrent Care Claim, Reduction or Termination): Aetna shall issue a decision within 36 hours of receipt of the request for an Appeal.

Pre-Service Claims

(May Include Concurrent Care Claim, Reduction or Termination): Aetna shall issue a decision within 15 calendar days of receipt of the request for an Appeal.

Post-Service Claims:

Aetna shall issue a decision within 30 calendar days of receipt of the request for an Appeal.

If you do not agree with such determination you have the right to file a second request for review within 60 days of receipt of the resolution letter. The notice of the decision will tell you what you need to do to seek an additional review.

Level Two Appeals

If Aetna upholds an adverse benefit determination at the first level of appeal, you or your authorized representative, have the right to file a level two appeal.

A level two Appeal of an adverse benefit determination, based on the service being experimental, cosmetic, or not medically necessary, shall be provided by at least two physicians or other health care professionals not involved in making the adverse benefit determination.

A level two appeal of an adverse determination of an urgent claim, not based on the service or supply being experimental, cosmetic, or not medically necessary, shall be provided by Aetna personnel not involved in making the adverse benefit determination.

A level two Appeal of an adverse benefit determination of a Pre-Service Claim or a Post-Service Claim will be reviewed by the Aetna Appeals Committee.

Adverse Benefit Determination.

Urgent Care Claims

(may include Concurrent Care Claim, Reduction or Termination): Aetna shall issue a decision within 36 hours of receipt of the request for a level two Appeal.

Pre-Service Claims

(may include Concurrent Care Claim, Reduction or Termination): Aetna shall issue a decision within 15 calendar days of receipt of the request for a level two Appeal.

Post-Service Claims

Aetna shall issue a decision within 30 calendar days of receipt of the request for a level two Appeal.

External Review for Claims Denied Based on the Service or Supply being not Medically Necessary

You may request an external review if you or your provider disagrees with Aetna's final decision. An external review is a review by an independent utilization review organization (IURO). Once the internal appeal process has been exhausted, eligible members may request an external review of the decision if the coverage denial, for which the member would be financially responsible, is based on lack of medical necessity.

The claim denial letter you receive from Aetna will describe the process to follow if you wish to pursue an external review. You must request an external review within 60 calendar days of the date you received the final claim denial letter. You also must include a copy of the final claim denial letter and all other pertinent information that supports your request.

Aetna will fax a "Petition for External Review" form to the Delaware Department of Insurance (Department) within three business days of your request and will also mail a copy of the form. The Department will assign an IURO to conduct the external review. Within five calendar days, the IURO will notify you of the review. You may submit supporting information that the IURO will consider within seven calendar days. Within seven business days Aetna will provide the IURO all information used in making the internal appeal decision. Within 45 calendar days, the IURO will provide written notice of its decision to you, Aetna and the Department. You may request an expedited review.

Aetna will abide by the decision of the IURO, except where Aetna can show conflict of interest, bias or fraud.

External Review for All Other Claim Denials

Aetna has established an external review process to give eligible members the opportunity of requesting an objective and timely independent review of certain coverage denials. Once the applicable appeal process has been exhausted, eligible members may request an external review of the decision if the coverage denial, for which the member would be financially responsible, involves more than \$500, and is based on the experimental or investigational nature of the proposed service or treatment.

The claim denial letter you receive from Aetna will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form.

You must submit the Request for External Review Form to Aetna within 60 calendar days of the date you received the final claim denial letter. You also must include a copy of the final claim denial letter and all other pertinent

information that supports your request. An external review organization (ERO) 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 a member's physician certifies that a delay in service would jeopardize the member's 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.

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

Georgia

You can call toll-free at 1-800-223-6857 to confirm that the preferred provider in question is in the network and/or accepting new patients.

Female 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.

You have direct access to the participating dermatologist provider of your choice and do not need a referral from your primary care physician(s) to access dermatologic benefits covered under your 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 listed 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 1-800-433-6917. Please have your Aetna member ID card available when you call.

Hawaii

Informed Consent

You 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
- Discuss all risks, benefits, and consequences of treatment and nontreatment

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

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 listed 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 precertification and other utilization review procedures and requirements

4. A description of the process for the selection of a PCP, any limitation on access to specialists, and the plan's standing referral policy
5. The emergency coverage and benefits, including any restrictions on emergency care services
6. The out-of-area coverage and benefits, if any
7. The enrollee's financial responsibility for copayments, deductibles, premiums, and any other out-of-pocket expenses
8. The provisions for continuity of treatment in the event a health care provider's participation terminates during the course of an enrollee's treatment by the provider
9. The appeals process, forms, and time frames for health care services appeals, complaints, and external independent reviews, administrative complaints, and utilization review complaints, including a phone number to call to receive more information from the health care plan concerning the appeals process
10. A statement of all basic health care services and all specific benefits and services to be provided to enrollees by a state law or administrative rule

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 that 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 that 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 that either reduces the coverage or benefits or increases the cost to such person

5. A description of the grievance and appeal procedures available under the health benefit plan and an insured's rights regarding termination, disenrollment, nonrenewal 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.

Managed Choice POS plan members have direct access to the participating primary chiropractic provider of their choice and do not need a referral from their primary care physician to access chiropractic benefits covered under their health benefit plan.

Customary Waiting Times

Routine	Within 7 days
Preventive Care	Within 8 weeks
Symptomatic, Nonurgent	Within 3 days
Urgent Complaint	Same Day/within 24 hours
Emergency	Immediately or referred to ER

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

Experimental Medical Treatment

Aetna supports physician requests for experimental treatment for life threatening illness:

- When there is disease progression after conventional treatment
- When there is no conventional treatment and the proposed treatment is delivered
- Under Institutional Review Board (IRB) supervision
- As part of a clinical trial to advance science

This policy supports all phases of clinical trials, including Phase I studies. Each request for such services is evaluated by the National Medical Excellence Unit.

For quality of care issues and life and health care insurance complaints you may contact:

Mid-Atlantic Regional Unit
980 Jolly Road,
P.O. Box 935
Blue Bell, PA 19422

or

Maryland Insurance Administration Life and Health Insurance Complaints
200 Saint Paul Place, Suite 2700
Baltimore, Maryland 21202-2272
Telephone: 1-800 492-6116 (toll free) or;
Phone: 410-468-2244
Facsimile: 410-468-2243

For assistance in resolving a billing or payment dispute with the health plan or a health care provider you may contact:

Mid-Atlantic Regional Unit
980 Jolly Road
P.O. Box 935
Blue Bell, PA 19422

or

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General, 16th Floor
200 Saint Paul Place
Baltimore, MD 21202
Telephone: 410-528-1840
Facsimile: 410-576-7040

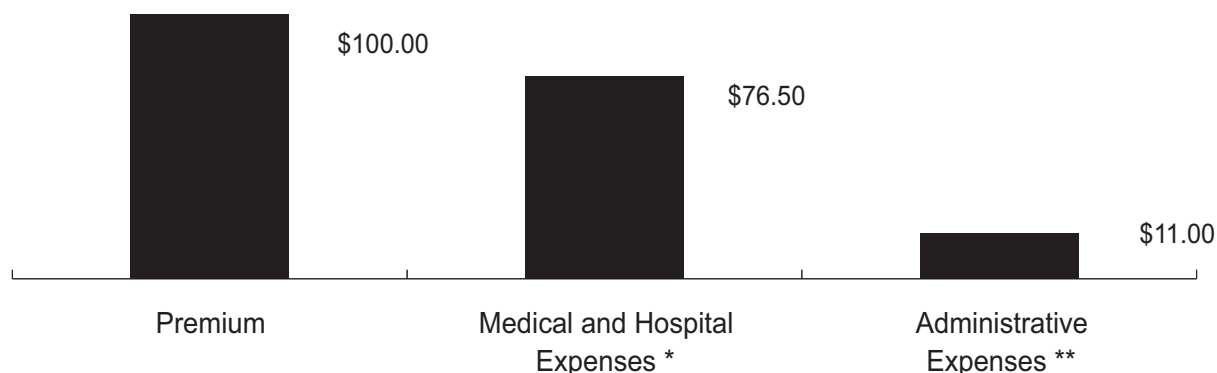
Nothing herein shall be construed to require Aetna to pay counsel fees or any other fees or costs incurred by a member in pursuing a complaint or appeal.

Our compensation to physicians who offer health care services to our insured members or enrollees may be based on a variety of payment mechanisms such as fee-for-service payments, discounted fee-for-service payments, or capitation. Bonuses may be used with these various types of payment methods.

If you desire additional information about methods of paying physicians or if you want to know which method(s) apply to your physician, please refer to your plan certificate or contact Member Services at the toll-free number on your Aetna ID card.

Terms		Percent of Physicians Paid Using this Described Method
Salary	<p>The example shows how Dr. Jones, an obstetrician gynecologist, would be compensated under each method of payment.</p> <p>A physician is an employee of Aetna and is paid compensation (monetary wages) for providing specific health care services.</p> <p>Since Dr. Jones is an employee of Aetna, she receives her usual bi-weekly salary regardless of how many patients she sees or the number of services she provides. During the months of providing prenatal care to Mrs. Smith, who is a member of Aetna, Dr. Jones' salary is unchanged. Although Mrs. Smith's baby is delivered by Cesarean section, a more complicated procedure than a vaginal delivery, the method of delivery will not have any effect upon Dr. Jones' salary.</p>	0%
Capitation	<p>A physician (or group of physicians) is paid a fixed amount of money per month by Aetna for each patient who chooses the physician(s) to be his or her doctor. Payment is fixed without regard to the volume of services that an individual patient requires.</p> <p>Under this type of contractual arrangement, Dr. Jones participates in an Aetna network. She is not employed by Aetna. Her contract with Aetna stipulates that she is paid a certain amount each month for patients who select her as their doctor. Since Mrs. Smith is a member of Aetna, Dr. Jones' monthly payment does not change as a result of her providing ongoing care to Mrs. Smith. The capitation amount paid to Dr. Jones is the same whether or not Mrs. Smith requires obstetric services.</p>	30%
Fee-for-Service	<p>A physician charges a fee for each patient visit, medical procedure, or medical service provided. An Aetna pays the entire fee for physicians it has under contract and an insurer pays all or part of that fee, depending on the type of coverage. The patient is expected to pay the remainder.</p> <p>Dr. Jones' contract with the insurer or Aetna states that Dr. Jones will be paid a fee for each patient visit and each service she provides. The amount of payment Dr. Jones receives will depend upon the number, types, and complexity of services, and the time she spends providing services to Mrs. Smith. Because Cesarean deliveries are more complicated than vaginal deliveries, Dr. Jones is paid more to deliver Mrs. Smith's baby than she would be paid for a vaginal delivery. Mrs. Smith may be responsible for paying some portion of Dr. Jones' bill.</p>	70%
Discounted Fee-for-Service	<p>Payment is less than the rate usually received by the physician for each patient visit, medical procedure, or service. This arrangement is the result of an agreement between the payer, who gets lower costs and the physician, who usually gets an increased volume of patients.</p> <p>Like fee-for-service, this type of contractual arrangement involves Aetna paying Dr. Jones for each patient visit and each delivery; but, under this arrangement, the rate, agreed upon in advance is less than Dr. Jones' usual fee. Dr. Jones expects that in exchange for agreeing to accept a reduced rate, she will serve a certain number of patients. For each procedure that she performs, Dr. Jones will be paid a discounted rate by Aetna.</p>	77%
Bonus	<p>A physician is paid an additional amount over what he or she is paid under salary, capitation, fee-for-service, or other type of payment arrangement. Bonuses may be based on many factors, including member satisfaction, quality of care, control of costs and use of services.</p> <p>Aetna rewards its physician staff or contracted physicians who have demonstrated higher than average quality and productivity. Because Dr. Jones has delivered so many babies and she has been rated highly by her patients and fellow physicians, Dr. Jones will receive a monetary award in addition to her usual payment.</p>	0%
Case Rate	<p>Aetna and the physician agree in advance that payment will cover a combination of services provided by both the physician and hospital for an episode of care.</p> <p>This type of arrangement stipulates how much Aetna will pay for a patient's obstetric services. All office visits for prenatal and postnatal care, as well as the delivery, and hospital-related charges are covered by one fee. Dr. Jones, the hospital, and other providers (such as an anesthesiologist) will divide payment from Aetna for the care provided to Mrs. Smith.</p>	0%

PREMIUM DOLLAR DISTRIBUTION DISCLOSURE



The cost of providing health care services in the State of Maryland exceeded the premium revenue per \$100.

* Medical and Hospital Expenses includes the costs of physician services, other professional services, referrals, emergency room visits, hospitalization and pharmacy.

** Administrative Expenses include, but may not be limited to: occupancy, depreciation and amortization, marketing, salaries, interest expense and accounting and corporate expenses.

Michigan

Contact the Michigan Office of Financial and Insurance Services at 517-373-0220 to verify participating providers' license or to access information on formal complaints and disciplinary actions filed or taken against participating providers.

To obtain further information on your health plan you may call Member Services at 1-800-208-8755 or refer to your plan documents.

New Jersey

Infertility Benefits (This mandate only applies to groups of 51 or more members):

New Jersey mandates certain infertility benefits. Your employer as permitted by law can elect not to provide coverage for the following procedures because they conflict with their bona fide religious tenets:

- In vitro fertilization (IVF)
- Embryo transfers
- Artificial insemination
- Zygote intra fallopian transfer (ZIFT)
- Gamete intra fallopian transfer (GIFT)
- Intracytoplasmic sperm injection (ICSI)

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

Mastectomy Coverage Information

Your plan will provide coverage for a minimum of 72 hours of inpatient care following a modified radical mastectomy and a minimum of 48 hours of inpatient care following a simple mastectomy.

A shorter stay is allowable if the patient and the patient's physician determine it is medically appropriate. The policy does not require a health care provider to obtain authorization from the insurer for prescribing the minimum 72 or 48 hours of inpatient care.

Physician Board Certification

73.95% of Aetna's participating physicians are board certified. If you would like to know if a specific physician is board certified, or is currently accepting new patients, please call the Member Services number listed on your ID card.

Appointment Waiting Times

Aetna's standard for customary waiting times for primary care physician appointments for urgent care is to be seen the same day or within 24 hours. Routine Care (Non Urgent) is divided into three (3) categories as :*Preventive care* it is the expectation to be seen within 8 weeks; *Symptomatic care* is to be seen within 3 days; and *Routine care* is to be seen within 7 days.

Member Rights

The "Member Rights" set forth pursuant to Regulations of the State of New Jersey provide that as a member you have the right to:

- Obtain a current directory of doctors participating within the network. Have access to a choice of participating specialists following a referral
- Be referred to participating specialists who are experienced in treating your illness if you have a chronic illness
- Have access to a primary care provider or a back-up 24 hours a day, 365 days a year for urgent care

- Call 911 in a potentially life-threatening situation without prior approval from Aetna
- Coverage for a medical screening exam in the emergency room to determine whether an emergency medical condition exists
- Receive up to 4 months of continued coverage — if medically necessary — from a doctor who has been terminated by Aetna
- Have a doctor make a utilization management denial of coverage
- Have your physician discuss with you pertinent details regarding your condition. Doctors are encouraged to discuss all medical treatment options, the nature and purpose of any recommended procedure and the potential risk and benefits of any reasonable alternatives to such recommended treatment.
- Know how Aetna pays participating doctors, so you know if there are financial incentives or disincentives tied to satisfaction, quality of care, control of costs and the use of services
- Appeal a utilization determination, first within Aetna and then through an independent organization for a \$25 filing fee
- Know you or your doctor cannot be penalized for filing a complaint or appeal
- Know how providers in our networks for these products have agreed to be paid each time they treat you (fee-for-service)
- Receive prompt notification of termination or changes in benefits, services or provider network no more than 30 days following the date that the change is effective
- File a complaint with Consumer Protection Services, Department of Banking and Insurance, 20 West State Street, 9th Floor, P.O. Box 329, Trenton, NJ 08625-0329, Toll free: 1-888-393-1062, Fax: 609-633-0807.

North Carolina

Direct Access Gynecology Program

Any female member 13 years or older may visit any participating gynecologist 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.

Experimental Treatment Information

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

Pennsylvania

This managed care plan may not cover all your health care expenses. Read your plan documents carefully to determine which health care services are covered. To contact the plan if you are a member, call the number listed on your ID card; all others, call 1-800-323-9930.

Rhode Island

Women's Health

Your Aetna health plan provides benefits for mastectomy and mastectomy-related services, including reconstruction and surgery to achieve symmetry between breasts; prosthesis; and treatment of physical complications of all stages of mastectomy, including lymph edemas.

Coverage is provided in accordance with your plan design, and is subject to plan limitations, copays, deductibles, coinsurance and referral requirements, if any, as outlined in the plan documents you received when you enrolled. For more information please contact Member Services at the number listed on your ID card.

South Dakota

In South Dakota, "concurrent review" is defined as a utilization review conducted during a patient's hospital stay or course of treatment in a facility or other inpatient or outpatient health care setting.

Utah

Choosing an Ob/Gyn as PCP

If your plan requires you to select a PCP to receive optimum coverage, you may select an obstetrician/gynecologist who has qualified as a primary care provider, as your provider from whom primary care services can be obtained.

Virginia

Important Information Regarding Your Insurance

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance or if you have additional questions, you may contact the insurance company issuing this insurance at the toll-free number on your Aetna ID card.

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Life and Health Division Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Phone: 804-371-9691
Fax: 804-371-9944

or

You may contact:

Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Toll Free: 1-877-310-6560
Richmond Metropolitan Area: 804-371-9032
e-mail: ombudsman@virginia.gov

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

Aetna Life Insurance Company is regulated as a Managed Care Health Insurance Plan (MCHIP) and as such, is subject to regulation by both the Virginia State Corporation Commission Bureau of Insurance and the Virginia Department of Health.

West Virginia

Religious Exemption

West Virginia Legislation mandates that group insurance policies and contracts that provide coverage for prescription drugs must include a rider providing coverage for contraceptive drugs and devices that are approved by the FDA or generics approved as substitutes by the FDA. However, "Religious Employers," as defined in the law, may elect not to include this coverage under their policy or contract. If a Religious Employer elects not to provide coverage for contraceptives, each member/enrollee covered under the contract is eligible to obtain a contraceptive rider directly from Aetna. Please refer to your plan administrator for specifics regarding your benefits.

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 to 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 to 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 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 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, you can request a certificate at any time. To request a Certificate of Prior Health Coverage, please contact Member Services at the telephone number listed on your ID card.

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, coverage will be provided to a person 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.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

Health benefits and health insurance plans are underwritten or administered 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.

Aetna is committed to Accreditation by the National Committee for Quality Assurance (NCQA) as a means of demonstrating a commitment to continuous quality improvement and meeting customer expectations. A complete listing of health plans and their NCQA accreditation status can be found on the NCQA website located at <http://www.ncqa.org/tabid/142/Default.aspx>.

To refine your search, we suggest you search these areas: **Managed Behavioral Healthcare Organizations** – for behavioral health accreditation; **Credentials Verification Organizations** – for credentialing certification; **Managed Care Organizations** – for HMO and PPO health plan accreditation; **Recognition Directory** – for physicians recognized by NCQA in the areas of heart/stroke care, diabetes care, back pain and systematic processes.

Health care providers who have been duly recognized by the NCQA Recognition Programs are annotated in the Physician 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. 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 www.ncqa.org/tabid/58/Default.aspx. If you do not have access to the Internet and would like a printed physician directory, please contact Member Services at the toll-free number shown on your Aetna ID card.

If you require language assistance from an Aetna representative, please call the Member Services number located on your ID card, and you will be connected with the language line if needed; or you may dial direct at 1-888-982-3862 (140 languages are available. You must ask for an interpreter). TDD 1-800-628-3323 (hearing impaired only).

Si requiere la asistencia de un representante de Aetna que hable su idioma, por favor llame al número de Servicios al Miembro que aparece en su tarjeta de identificación y se le comunicará con la línea de idiomas si es necesario; de lo contrario, puede llamar directamente al 1-888-982-3862 (140 idiomas disponibles. Debe pedir un intérprete). TDD-1-800-628-3323 (sólo para las personas con impedimentos auditivos).