

Important Disclosure Information

Aetna MedicareSM Plan (HMO) and Aetna MedicareSM Plan (PPO)

Note: Medicare Advantage plan requirements govern and supersede any state or general disclosures contained within.

Plan Benefits

Covered services include most types of treatment provided by primary care physicians, specialists and hospitals. However, the health plan does exclude and/or include limits on coverage for some services, including but not limited to, cosmetic surgery and experimental procedures. In addition, in order to be covered, all services, including the location (type of facility), duration and costs of services, must be medically necessary as defined 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 Summary of Benefits, Evidence of Coverage 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.

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.aetnamedicare.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. Your plan documents will also list any direct access benefits that do not require referrals. 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

Under Aetna Medicare Open Access HMO and PPO plans you may directly access participating providers without a PCP referral, subject to the terms and conditions of the plan and cost sharing requirements. Participating providers will be responsible for obtaining any required preauthorization of services from Aetna. Refer to your specific plan documents for details.

Aetna Medicare PPO plans have direct-access benefits. Direct-access benefits allow you to directly access participating providers and nonparticipating providers without a PCP referral, subject to additional cost sharing requirements. Even so, you may be able to reduce your out-of-pocket expenses considerably by using participating providers. Refer to your specific plan brochure for details. If your plan does not specifically cover direct-access benefits (self-referred or nonparticipating provider benefits) and you go directly to a specialist or hospital for nonemergency or nonurgent care without a referral, you must pay the bill yourself unless the service is specifically identified as a direct-access benefit in your plan documents.

Direct Access Ob/Gyn Program

This program allows female members to visit, without a referral, any participating obstetrician or gynecologist for a routine well-woman exam, including a 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 continue to 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 the organization may have different referral policies.

Precertification

If required by your plan, 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.

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 have Medicare coverage and 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 layperson, 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 Medicare Service Area

If you are traveling outside your Aetna Medicare service area; 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 severe vomiting, earaches, sore throats or fever, are considered “urgent care” outside your Aetna Medicare 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, it may be necessary to provide us with additional information. We will send you an Emergency Room Notification Report to complete, or a Member Services representative can take this information by telephone.

Follow-up Care after Emergencies

All follow-up care should be coordinated by your PCP. Follow-up care with nonparticipating providers is only covered with a referral from your PCP and prior authorization from Aetna. Whether you were treated inside or outside your Aetna Medicare service area, if your plan requires referrals, you must obtain a referral before any follow-up care can be covered. If your plan does not require referrals you should contact Aetna at the number on your ID card before care is received at non-network facilities. Suture removal, cast removal, X-rays and clinic and emergency room revisits are some examples of follow-up care.

PPO plans: All in-network and out-of-network follow-up care will be covered under the terms and conditions of your plan.

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.aetnamedicare.com or the Aetna Medicare 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.

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. 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.aetnamedicare.com. 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.

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 specifically for Medicare members and another that also includes commercial members. A depression screening and treatment referral component is available to any Medicare member who:

- has been determined to be at high risk for complications due to a medical condition identified based on an initial screening that is completed when entering the plan.
- has had a cardiac valve replacement.
- are already involved in one of the Aetna Medical Disease Management programs.

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.

Claims Payment for Non-Network Providers

If your plan provides coverage for services rendered by non-network providers, you should be aware that Aetna determines the allowable fee for a non-network provider by referring to the Original Medicare approved amount, which is the maximum amount that Original Medicare allows a provider to accept. Charges by a non-network provider in excess of the Medicare approved amount will not be covered by Aetna, nor are they the responsibility of the member. You may be responsible for any charges Aetna determines are not covered under your plan, as well as any cost sharing outlined in your plan documents.

Technology Review

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

- Study 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. You can find them online 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 will 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 to 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 retrospectively 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.

Organization Determinations, Coverage Determinations, Grievances and Appeals

As a member of Aetna Medicare Plan (HMO) (PPO), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state.

For detailed information about Aetna's grievance, organization determination, and appeals processes, forms and our contact information, please refer to our Aetna Medicare website: http://www.aetnamedicare.com/plan_choices/advantage_appeals_grievances.jsp

As a member of Aetna Medicare Plan (HMO) (PPO), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost.

You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state.

For detailed information about Aetna's grievance, coverage determination, and appeals processes, forms and our contact information, please refer to our Aetna Medicare website: http://www.aetnamedicare.com/plan_choices/rx_exceptions_appeals.jsp

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.

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

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

TTY/TDD 1-888-760-4748 (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 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.

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 lymph edemas.

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.

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

Health insurance plans are offered by Aetna Health Inc., Aetna Health of California Inc. and/or Aetna Life Insurance Company. Coverage is provided through a Medicare Advantage organization or a Medicare Prescription Drug Plan Sponsor with a Medicare contract. Benefits, formulary, pharmacy network, premium, and/or copayments/coinsurance may change on January 1 of each year. Please contact Aetna Medicare for details.

This material is for informational purposes only. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change.

Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional.