Appeal Information Packet and Other Important Disclosure Information Arizona

Health Care Insurer Appeals Process Information Packet - Aetna Health Inc./Corporation Health Insurance Company

PLEASE READ THIS NOTICE CAREFULLY AND KEEP IT FOR FUTURE REFERENCE. IT CONTAINS IMPORTANT INFORMATION ABOUT HOW TO APPEAL DECISIONS WE MAKE ABOUT YOUR HEALTH CARE COVERAGE.

Getting Information about the Health Care Appeals Process

Help in Filing an Appeal: Standardized Forms and Consumer Assistance from the Department of Insurance

We must send you a copy of this information packet when you first receive your policy, and within 5 business days after we receive your request for an appeal. When your insurance coverage is renewed, we must also send you a separate statement to remind you that you can request another copy of this packet. We will also send a copy of this packet to you or your treating provider at any time upon request. To request a copy, just call the Member Services number printed on your Member ID card.

At the back of this packet, you will find forms you can use for your appeal. The Arizona Insurance Department ("the Department") developed these forms to help people who want to file a health care appeal. You are not required to use them. We cannot reject your appeal if you do not use them. If you need help in filing an appeal, or you have questions about the appeals process, you may call the Department's Consumer Assistance Office at (602) 912-8444 or 1 (800) 325-2548, or you may call us at the Member Services number printed on your Member ID card.

How to Know When You Can Appeal

When we do not authorize or approve a service or pay for a claim, we must notify you of your right to appeal that decision. Your notice may come directly from us, or through your treating provider.

Decisions You Can Appeal

You can appeal the following decisions:

1. We do not approve a service that you or your treating provider has requested.
2. We do not pay for a service that you have already received.
3. We do not authorize a service or pay for a claim because we say that it is not "medically necessary."
4. We do not authorize a service or pay for a claim because we say that it is not covered under your insurance policy, and you believe it is covered.
5. We do not notify you, within 10 business days of receiving your request, whether or not we will authorize a requested service.
6. We do not authorize a referral to a specialist.

Decisions You Cannot Appeal

You cannot appeal the following decisions:

1. You disagree with our decision as to the amount of "reasonable charge." Where applicable, a reasonable charge is a charge for a covered benefit which is determined by us to be the prevailing charge level made for the service or supply in the geographic area where it is furnished. We may take into account factors such as the complexity, degree of skill needed, type or specialty of the provider, range of services provided by a facility, and the prevailing charge in other areas in determining the reasonable charge for a service or supply that is unusual or is not often provided in the area or is provided by only a small number of providers in the area.

2. You disagree with how we are coordinating benefits when you have health insurance with more than one insurer.
3. You disagree with how we have applied your claims or services to your plan deductible.
4. You disagree with the amount of coinsurance or copayments that you paid.
5. You disagree with our decision to issue or not issue a policy to you.
6. You are dissatisfied with any rate increases you may receive under your insurance policy.
7. You believe we have violated any other parts of the Arizona Insurance Code.

If you disagree with a decision that cannot be appealed according to this list, you may still file a complaint with us by calling the Member Services number printed on your Member ID Card. In addition, you may also file such complaints with the Arizona Department of Insurance, Consumer Affairs Division, 2910 N. 44th Street, Second Floor, Phoenix, AZ 85018. Telephone: (602) 255-4421.

Who Can File an Appeal

Either you or your treating provider, on your behalf, can file an appeal. At the end of this packet is a form that you may use for filing your appeal. You are not required to use this form. If you wish, you can send us a letter with the same information. If you decide to appeal our decision to deny authorization for a service, you should tell your treating provider so he/she can help you with the information needed to present your case.

Description of the Appeals Process

I. Levels of Review

We offer expedited as well as standard appeals for Arizona residents. Expedited appeals are for urgently needed services that you have not yet received. Standard appeals are for non-urgent service requests and denied claims for services already provided. Both types of appeals follow a similar process, except that we process expedited appeals much faster because of the patient's condition.

Each type of appeal has three levels, as follows:

Expedited Appeals
(For urgently needed services you have not yet received)
Level 1. - Expedited Medical Review
Level 2. - Expedited Appeal
Level 3. - Expedited External, Independent Medical Review

Standard Appeals
(For non-urgent services or denied claims)
Level 1. - Informal Reconsideration
Level 2. - Formal Appeal
Level 3. - External, Independent Medical Review

We make the appeal decisions at Level 1 and Level 2. An outside reviewer, who is completely independent from our company, makes Level 3 appeal decisions. You are not responsible to pay the costs of the external review if you choose to appeal to Level 3. These three levels of Appeal are discussed in detail below:

Expedited Appeal Process For Urgently Needed Services Not Yet Provided

Expedited Medical Review (Level 1)

Your Request: You may obtain Expedited Medical Review of your denied request for a service that has not already been provided if:

- You have coverage with us;
- We denied your request for a covered service; and
- Your treating provider certifies in writing and provides supporting documentation that the time required to process your request through the Informal Reconsideration and Formal Appeal process (about 60 days) is likely to cause a significant negative change in your medical condition. (At the end of this packet is a form that your provider may use for this purpose. Your provider could also send a letter or self made form with similar information.) Your treating provider must send the certification and documentation to:

Name:	Aetna Health Inc./Corporate Health Insurance Company Attn: Medical Resolution Team
Address:	P.O. Box 14596 Lexington, KY 40512
Phone:	800-305-7342
Fax:	818-932-6566

Our Decision: We have 1 business day after we receive the information from the treating provider to decide whether we should change our decision and authorize your requested service. Within that same business day, we must call and inform you and your treating provider of our decision. We will then mail our written decision to both you and your treating provider. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request: You may immediately appeal to Level 2.

If we grant your request: We will authorize the service and the appeal process is complete.

If we refer your case to Level 3: We may decide to skip the Level 1 and Level 2 expedited appeal process and send your case directly to an independent reviewer at Level 3.

Expedited Appeal (Level 2)

Your request: If we deny your request at Level 1, Expedited Medical Review you may request an Expedited Appeal. After you receive our Level 1 denial, your treating provider must immediately send us a written request (to the same person and address listed above under Level 1) to tell us you are appealing to Level 2, Expedited Appeal. To help your appeal, your provider should also send us any additional information that hasn't already been sent to show why you need the requested service.

Our decision: We have 3 business days after we receive the request to make our decision.

If we deny your request: You may immediately appeal to Level 3, Expedited External, Independent Medical Review.

If we grant your request: We will authorize the service and the appeal process is complete.

If we refer your case to Level 3: We may decide to skip the Level 2, Expedited Appeal and send your case directly to an independent reviewer at Level 3.

Expedited External, Independent Review (Level 3)

Your request: You may appeal to Level 3 only after you have appealed through Levels 1 and 2 of the expedited appeal process. You have only 5 business days after you receive our Level 2, Expedited Appeal decision to send us your written request for Expedited External Independent Review. Send your request and any more supporting information to:

Name:	Aetna Health Inc./Corporate Health Insurance Company Attn: Medical Resolution Team
Address:	P.O. Box 14596 Lexington, KY 40512
Phone:	800-305-7342
Fax:	818-932-6566

Neither you nor your treating provider is responsible for the cost of any external independent review.

The process: There are two types of Level 3 appeals, depending on the issues in your case:

(1) Medical Necessity
These are cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for are not medically necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization ("IRO"), that has contracted with the Arizona Insurance Department, and not connected with our company. The IRO provider must be a provider who typically manages the condition under review.

(2) Contract Coverage
These are cases where we have denied coverage because we believe the requested service is not covered under your insurance policy. For contract coverage cases, the Arizona Insurance Department is the independent reviewer.

Medical Necessity Cases

Within 1 business day of receiving your request, we must:

1. Mail a written acknowledgement of the request to the Director of Insurance, you, and your treating provider.
2. Send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

Within 2 business days of receiving our information, the Insurance Director must send all the submitted information to an external independent review organization (the "IRO").

Within 5 business days of receiving the information the IRO must make a decision and send the decision to the Insurance Director.

Within 1 business day of receiving the IRO's decision, the Insurance Director must mail a notice of the decision to us, you, and your treating provider.

The decision (medical necessity): If the IRO decides that we should provide the service, we must authorize the service. If the IRO agrees with our decision to deny the service, the appeal process is complete. Your only further option is to pursue your claim in Superior Court.

Contract Coverage Cases

Within 1 business day of receiving your request, we must:

1. Mail a written acknowledgement of your request to the Insurance Director, you, and your treating provider.
2. Send the Director of Insurance: the request for review, your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and any clinical reasons for our decision; and the relevant portions of our utilization review guidelines.

Within 2 business days of receiving this information, the Insurance Director must determine if the service or claim is covered, issue a decision, and send a notice to us, you, and your treating provider.

Referral to the IRO for contract coverage cases: The Insurance Director is sometimes unable to determine issues of coverage. If this occurs, the Insurance Director will forward your case to an IRO. The IRO will have 5 business days to make a decision and send it to the Insurance Director. The Insurance Director will have 1 business day after receiving the IRO's decision to send the decision to us, you, and your treating provider.

The decision (contract coverage): If you disagree with the Insurance Director's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If we disagree with the Director's final decision, we may also request a hearing before the OAH. A hearing must be requested within 30 days of receiving the Director's decision. OAH must promptly schedule and complete a hearing for appeals from expedited Level 3 decisions.

Standard Appeal Process For Non-Urgent Services and Denied Claims

Informal Reconsideration (Level 1)

Your request: You may obtain Informal Reconsideration of your denied request for a service or a denied claim for services already provided to you if:

- You have coverage with us;
- We denied your request for a covered service or denied your claim for services already provided,
- You do not qualify for an expedited appeal, and
- You or your treating provider asks for Informal Reconsideration within 2 years of the date we first denied the requested service or claim by calling, writing, or faxing your request to:

Name:	Aetna Health Inc./Corporate Health Insurance Company Attn: Medical Resolution Team
Address:	P.O. Box 14596 Lexington, KY 40512
Phone:	800-305-7342
Fax:	818-932-6566

Our acknowledgement: We have 5 business days after we receive your request for Informal Reconsideration ("the receipt date") to send you and your treating provider a notice that we received your request.

Our decision: We have 30 days after the receipt date to decide whether we should change our decision and authorize your requested service or pay your claim. Within that same 30 days, we must send you and your treating provider our written decision. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request: You have 60 days to appeal to Level 2, Formal Appeal.

If we grant your request: The decision will authorize the service or pay the claim and the appeal process is complete.

If we refer your case to Level 3: We may decide to skip Level 1 and Level 2 standard appeal process and send your case directly to an independent reviewer at Level 3.

Formal Appeal (Level 2)

Your request: You may request a Formal Appeal if we denied your request or claim at Level 1. After you receive our Level 1, Informal Reconsideration denial, you or your treating provider must send us a written request within 60 days to tell us you are appealing to a Level 2, Formal Appeal. To help us make a decision on your appeal, you or your provider should also send us any additional information (that you haven't already sent us) to show why we should authorize the requested service or pay the claim. Send your appeal request and information to:

Name:	Aetna Health Inc./Corporate Health Insurance Company Attn: Medical Resolution Team
Address:	P.O. Box 14596 Lexington, KY 40512
Phone:	800-305-7342
Fax:	818-932-6566

Our acknowledgement: We have 5 business days after we receive your request for Formal Appeal ("the receipt date") to send you and your treating provider a notice that we received your request.

Our decision: For a denied service that you have not yet received, we have 30 days after the receipt date to decide whether we should change our decision and authorize your requested service. For denied claims, even though we have up to 60 days to decide whether we should change our decision and pay your claim, we aim to decide such matters within 30 days. We will send you and your treating provider our decision in writing. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request or claim: You have 30 days to appeal to Level 3, External, Independent Medical Review.

If we grant your request: We will authorize the service or pay the claim and the appeal process is complete.

If we refer your case to Level 3: We may decide to skip the Level 2, Formal Appeal and send your case directly to an independent reviewer at Level 3.

External, Independent Review (Level 3)

Your request: You may appeal to Level 3 only after you have appealed through Levels 1 and 2 of the Standard Appeal process. You have 30 days after you receive our Level 2 decision to send us your written request for External Independent Review. Send your request and any more supporting information to:

Name:	Aetna Health Inc./Corporate Health Insurance Company Attn: Medical Resolution Team
Address:	P.O. Box 14596 Lexington, KY 40512
Phone:	800-305-7342
Fax:	818-932-6566

Neither you nor your treating provider is responsible for the cost of any external independent review.

The process: There are two types of Level 3 appeals, depending on the issues in your case:

(1) Medical Necessity
These are cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for, are not medically necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization ("IRO"), that is procured by the Arizona Insurance Department, and not connected with our company. For medical necessity cases, the IRO provider must be a provider who typically manages the condition under review.

(2) Contract Coverage
These are cases where we have denied coverage because we believe the requested service is not covered under your insurance policy. For contract coverage cases, the Arizona Insurance Department is the independent reviewer.

Medical Necessity Cases

Within 5 business days of receiving your request, we must:

1. Mail a written acknowledgement of the request to the Director of Insurance, you, and your treating provider.
2. Send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

Within 5 days of receiving our information, the Insurance Director must send all the submitted information to an external independent review organization (the "IRO").

Within 21 days of receiving the information the IRO must make a decision and send the decision to the Insurance Director.

Within 5 business days of receiving the IRO's decision, the Insurance Director must mail a notice of the decision to us, you, and your treating provider.

The decision (medical necessity): If the IRO decides that we should provide the service or pay the claim, we must authorize the service or pay the claim. If the IRO agrees with our decision to deny the service or payment, the appeal process is complete. Your only further option is to pursue your claim in Superior Court.

Contract Coverage Cases

Within 5 business days of receiving your request, we must:

1. Mail a written acknowledgement of your request to the Insurance Director, you, and your treating provider.
2. Send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues, including a statement of our decision; the criteria used and any clinical reasons for our decision; and the relevant portions of our utilization review guidelines.

Within 15 business days of receiving this information, the Insurance Director must determine if the service or claim is covered, issue a decision, and send a notice to us, you, and your treating provider. If the Director decides that we should provide the service or pay the claim, we must do so.

Referral to the IRO for contract coverage cases: The Insurance Director is sometimes unable to determine issues of coverage. If this occurs, the Insurance Director will forward your case to an IRO. The IRO will have 21 days to make a decision and send it to the Insurance Director. The Insurance Director will have 5 business day after receiving the IRO's decision to send the decision to us, you, and your treating provider.

The decision (contract coverage): If you disagree with Insurance Director's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If we disagree with the Director's final decision, we may also request a hearing before the OAH. A hearing must be requested within 30 days of receiving the coverage issue determination. The OAH has rules that govern the conduct of its hearing proceedings.

II. Obtaining Medical Records

Arizona law (A.R.S. §12-2293) permits you to ask for a copy of your medical records. Your request must be in writing and must specify who you want to receive the records. The health care provider who has your records will provide you or the person you specified with a copy of your records.

Designated Decision-Maker: If you have a designated health care decision-maker, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your health care decision-maker or a person designated in writing by your health care decision-maker unless you limit access to your medical records only to yourself or your health care decision-maker.

Confidentiality: Medical records disclosed under A.R.S. §12-2293 remain confidential. If you participate in the appeal process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other people.

III. Documentation for an Appeal

If you decide to file an appeal, you must give us any material justification or documentation for the appeal at the time the appeal is filed. If you gather new information during the course of your appeal, you should give it to us as soon as you get it. You must also give us the address and phone number where you can be contacted. If the appeal is already at Level 3, you should also send the information to the Department.

IV. The Role of the Director of Insurance

Arizona law (A.R.S. §20-2533(F)) requires "any member who files a complaint with the Department relating to an adverse decision to pursue the review process prescribed" by law. This means, that for decisions that may be appealed, you must pursue the health care appeals process before the Insurance Director can investigate a complaint you may have against our company based on the decision at issue in the appeal.

The appeal process requires the Director to:

1. Oversee the appeals process.
2. Maintain copies of each utilization review plan submitted by insurers.
3. Receive, process, and act on requests from an insurer for External, Independent Review.
4. Enforce the decisions of insurers.
5. Review decisions of insurers.
6. Report to the Legislature.
7. Send, when necessary, a record of the proceedings of an appeal to Superior Court or to the Office of Administrative Hearings (OAH).
8. Issue a final administrative decision on coverage issues, including the notice of the right to request a hearing at the OAH.

V. Receipt of Documents

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. "Properly addressed," means your last known address.

We want you to know℠

Once you have completed this Form, submit to:
Aetna Health Inc./Corporate Health Insurance Company
Medical Resolution Team
P.O. Box 14596
Lexington, KY 40512
Fax: 818-932-6566

Health Care Appeal Request Form

You may use this form to tell your insurer you want to appeal a denial decision.

Insured Member's Name______________________________ Member ID#______________________________

Name of representative pursuing appeal, if different from above______________________________

Mailing Address______________________________ Phone #______________________________

City______________________ State ____________ Zip Code______________________________

Type of Denial: Denied Claim for Service Already Provided Denied Service Not Yet Received

Name of Insurer that denied the claim/service:______________________________

If you are appealing your insurer's decision to deny a service you have not yet received, will a 30 to 60 day delay in receiving the service likely cause a significant negative change in your health? If your answer is "yes", you may be entitled to an expedited appeal. Your treating provider must sign and send a certification and documentation supporting the need for an expedited appeal.

What decision are you appealing? (Explain what you want your insurer to authorize or pay for.)

____
____
____
____

Explain why you believe the claim or service should be covered: (Attach additional sheets of paper, if needed.)

____
____
____
____

If you have questions about the appeals process or need help to prepare your appeal,
you may call the Department of Insurance
Consumer Assistance number (602) 912-8444 or 1 (800) 325-2548
You may also call the Aetna Member Services number on the member's ID card.

Make sure to attach everything that shows why you believe your insurer should cover your claim or authorize a service, including: Medical records Supporting documentation (letter from your doctor, brochures, notes, receipts, etc.) ** Also attach the certification from your treating provider if you are seeking expedited review.

______________________________ ______________________________
Signature of insured or authorized representative **Date**

We want you to know℠

Once you have completed this Form, submit to:
Aetna Health Inc./Corporate Health Insurance Company
Medical Resolution Team
P.O. Box 14596
Lexington, KY 40512
Fax: 818-932-6566

Provider Certification Form For Expedited Medical Reviews

(You and your provider may use this form when requesting an expedited appeal.)

A patient who is denied authorization for a covered service is entitled to an expedited appeal if the treating provider certifies and provides supporting documentation that the time period for the standard appeal process (about 60 days) "is likely to cause a significant negative change in the patient's medical condition at issue."

PROVIDER INFORMATION

Treating Physician/Provider______________________________

Phone #______________________ FAX #______________________

Address______________________________

City______________________ State____________ Zip Code______________

PATIENT INFORMATION

Patient's Name______________________________ Member ID#______________

Phone #______________________ FAX #______________________

Address______________________________

City______________________ State____________ Zip Code______________

INSURER INFORMATION

Insurers Name______________________________

Phone #______________________ FAX #______________________

Address______________________________

City______________________ State____________ Zip Code______________

- Is the appeal for a service that the patient has already received? ______ Yes ______ No
  If "Yes", the patient must pursue the standard appeals process and cannot use the expedited appeals process.
  If "No", continue with this form.
- What service denial is the patient appealing?

____

____

- Explain why you believe the patient needs the requested service and why the time for the standard appeal process will harm the patient.______________________________

____

Attach additional sheets, if needed, and include: Medical records Supporting documentation

If you have questions about the appeals process or need help regarding this certification, you may call the Department of Insurance Consumer Assistance number (602) 912-8444 or 1 (800) 325-2548. You may also call Aetna Member Services number on the member's ID card.

I certify, as the patient's treating provider, that delaying the patient's care for the time period needed for the informal reconsideration and formal appeal processes (about 60 days) is likely to cause a significant negative change in the patient's medical condition at issue.

Provider's Signature______________________________**Date**______________________

We want you to know℠

THIS DISCLOSURE FORM IS ONLY A SUMMARY.
THE PLAN'S EVIDENCE OF COVERAGE SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

COMBINED SMALL AND LARGE GROUP DISCLOSURE FORM

AETNA HEALTH INC., CORPORATE HEALTH INSURANCE COMPANY (ARIZONA)

Please read this notice carefully.

This notice contains important information you should know before you enroll.

*** * * * ***

This Disclosure form is only a summary.

*** * * The Company's policy, Certificate of Coverage (COC) or Evidence of Coverage should be consulted to determine governing contractual provisions * * ***

A. COMPANY'S PRIMARY CARE PHYSICIANS ROSTER

Refer to the Physician Directory for a list of Plan Primary Care Physicians, each physician's degree, practice specialty, and year first licensed to practice medicine and, if different, the year initially licensed to practice in Arizona.

B. PREMIUM

The monthly premium cost of your plan will be provided separately by your plan sponsor.

The portion of the premium paid by an employee will depend on the amount of your employer's contribution. Aetna* may also adjust the premium rates and/or the manner of calculating premiums effective as of any premium due date upon 60 days prior written notice to contract holder, provided that no such adjustment will be made during the initial term except to reflect changes in applicable law or regulation or a judicial decision having a material impact on the cost of providing covered benefits to members.

The premium may also include an experience factor. If claims are more than expected, the employer may owe additional premium. If claims are less than expected, the employer may receive a refund. This feature applies only to contracts that are retrospectively rated, not fully insured contracts.

Rating and Pertinent Factors.

The initial medical rates quoted for your group are subject to adjustment at the commencement of any subsequent rating period based upon the then-current new business rates for groups of similar size and demographic characteristics that have purchased similar benefits. Demographic characteristics of a group include age, gender, and group size. They may not include claims experience, health status, industry or duration of coverage.

The rates for your group may be adjusted at the commencement of any rating period based upon your group's claims experience, health status, industry or duration since issue. The actual adjustment will be determined by comparing your group's claim experience to the claim experience of other groups of similar size and demographic characteristics.

The foregoing information is subject to change based on future changes to your state's insurance law or other regulatory requirements, as well as future changes to rating practices. Any such changes will be communicated to your group.

Contribution and Participation.

Contribution requirements: For small groups, employer must contribute a minimum of 50% of the employee-only rate. For large groups, employer must contribute a minimum of 50% of the total plan or 75% of the employee-only rate.

Participation requirements: Less than 4 eligible employees require a minimum of 100% participation, excluding valid benefit waivers. 4 or more employees require a minimum of 75% participation, excluding valid benefit waivers.

* Aetna refers to Aetna Health Inc. and/or Corporate Health Insurance Company.

C. MEMBER COST SHARING

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

D. HOW AND WHERE TO OBTAIN SERVICES

1. **Selecting a Participating Primary Care Physician.**

   At the time of enrollment, each member should select a participating primary care physician (PCP) from Aetna's directory of participating providers to access covered benefits. The choice of a PCP is made solely by the member. If the member is a minor or otherwise incapable of selecting a PCP, the subscriber should select a PCP on the member's behalf.

2. **The Primary Care Physician.**

   For most Aetna plans, members are required to select a PCP who participates in the network. The PCP can provide primary care as well as coordinate your overall care. Members should consult their PCP when they are sick or injured to help determine the care that is needed. Your PCP should issue referrals to participating specialists and facilities for certain services. For some services, your PCP is required to obtain prior authorization from Aetna. Except for those benefits described in the plan documents as direct access benefits, plans with self-referral to participating providers (Aetna Open Access® or Aetna Choice® POS), plans that include benefits for nonparticipating provider services (Aetna Choice POS, USAccess® or QPOS®), or in an emergency, members will need to obtain a referral authorization ("referral") from their PCP before seeking covered non-emergency specialty or hospital care. Check your plan documents for details.

3. **Availability of Providers.**

   Aetna cannot guarantee the availability or continued participation of a particular provider. Either Aetna or any participating provider may terminate the provider contract or limit the number of members that will be accepted as patients. If the PCP initially selected cannot accept additional patients, the member will be notified and given an opportunity to make another PCP selection. The member must then cooperate with Aetna to select another PCP.

4. **Changing a PCP.**

   Members may change their PCP at any time by calling the Member Services toll-free telephone number listed on the Aetna ID card or by written or electronic submission of Aetna's change form. Members may contact Aetna to request a change form or for assistance in completing that form. The change will become effective upon Aetna's receipt and approval of the request.

5. Unless an exception is obtained from Aetna, you must receive all routine care through participating providers. In contrast, medical emergencies are covered no matter where or from whom you receive care. When traveling outside the Aetna service area, you can be covered for urgent care through any licensed physician or facility. Aetna covers urgent care services outside your home service area if the services are medically necessary and immediately required because of unforeseen illness, injury or condition and it was not reasonable, given the circumstances, to obtain services through your home service area.

6. See the attached list of locations of contracted hospitals and outpatient treatment centers. Also attached is a map or list of the areas served.

E. PREAUTHORIZATION AND REFERRAL PROCEDURES

1. **Ongoing Reviews.**

   Aetna conducts ongoing reviews of those services and supplies which are recommended or provided by health professionals to determine whether such services and supplies are covered benefits. If Aetna determines that the recommended services and supplies are not covered benefits, the member will be notified. If a member wishes to appeal such determination, the member may then contact Aetna to seek a review of the determination. Please refer to the Claim Determination Procedures/Complaints and Appeals/External Independent Medical Review/Dispute Resolution section.

2. **Continuity of Care.**

   For new members of Aetna, coverage will be provided for new members to continue an active, ongoing course of treatment with the member's current health care provider during a transitional period, upon the member's written request to Aetna, as follows:

1. For a member with a life-threatening disease or condition on their effective date, the transitional period is 30 days after the member's effective date of coverage; or
2. For a member who has entered the third trimester of pregnancy on their effective date, the transitional period includes the delivery and any care up to 6 weeks after the delivery that is related to the delivery.

If a member's participating health care provider stops participating with Aetna for reasons other than medical incompetence or unprofessional conduct, on written request from the member to Aetna, Aetna will continue coverage for an active, ongoing course of treatment with that participating health care provider during a transitional period after the date of the provider's termination, as follows:

1. For a member with a life-threatening disease or condition, the transitional period is 30 days after the date of the participating provider's termination date; or
2. For a member who has entered the third trimester of pregnancy on the participating provider's termination date, the transitional period includes the delivery and any care up to six weeks after the delivery that is related to the delivery.

Aetna will authorize the coverage for the transitional period only if the health care provider agrees to the following in writing:

1. to accept Aetna's normal reimbursement rates for similar services;
2. to adhere to Aetna's quality standards and to provide medical information related to such care; and
3. to adhere to Aetna's policies and procedures.

This provision shall not be construed to require Aetna to provide coverage for benefits not otherwise covered under the COC.

3. **Referral Policy.**

The following points are important to remember regarding referrals:

- The referral is how the member's PCP arranges for a member to be covered for necessary, appropriate specialty care and follow-up treatment.
- Members should discuss the referral with their PCP to understand what specialist services are being recommended and why.
- If the specialist recommends any additional treatments or tests that are covered benefits, the member may need to get another referral from the PCP prior to receiving the services. If the member does not get another referral for these services, the member may be responsible for payment.
- Your PCP may indicate on your referral form that your referral will apply to more than one visit to a specialist to whom you have been referred. Depending upon the terms of your referral, you may have to acquire another referral form from your PCP for continuing specialist care.
- Except in emergencies, all hospital admissions and outpatient surgery require a prior referral from the member's PCP and prior authorization by Aetna.
- If it is not an emergency and the member goes to a doctor or facility without a referral, the member must pay the bill.
- Referrals are valid for 90 days as long as the individual remains an eligible member of the plan.
- 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 provides that, except for applicable cost sharing, the member will not have to pay the charges for covered benefits, as long as the individual is a member at the time the services are provided.

4. **Direct Access.**

Under Aetna Choice POS, USAccess and QPOS plans a member may directly access nonparticipating providers without a PCP referral, subject to cost-sharing requirements. Even so, you may be able to reduce your out-of-pocket expenses considerably by using the participating providers. Refer to your specific plan brochure for details.

If your plan does not specifically cover self-referred or nonparticipating provider benefits and you go directly to a specialist or hospital for non-emergency or non-urgent 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.

Under Aetna Open Access and Aetna Choice POS plans, a member 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 brochure for details.

5. **Direct Access Ob/Gyn Program.**

   This program allows female members to visit any participating gynecologist for a routine well-woman exam, including a Pap smear, and for gynecologic problems. Gynecologists may also refer a woman directly to other participating providers for covered 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.

6. **Health Care Provider Network.**

   Certain PCPs are affiliated with integrated delivery systems, IPAs or other provider groups, and members who select these PCPs will generally be referred to specialists and hospitals within that system, association or group. However, if your medical needs extend beyond the scope of the affiliated providers, you may request coverage for services provided by nonaffiliated network physicians and facilities. In order to be covered, services provided by nonaffiliated network providers may require prior authorization from Aetna and/or the integrated delivery systems or other provider groups.

   Members should note that other health care providers (e.g., specialists) may be affiliated with other providers through systems, associations or groups. These systems, associations or groups ("organization") or their affiliated providers may be compensated by Aetna through a capitation arrangement or other global payment method. The organization then pays the treating provider directly through various methods. Members should ask their provider how that provider is being compensated for providing health care services to the member and if the provider has any financial incentive to control costs or utilization of health care services by the member.

7. **Precertification.**

   Precertification is the process of collecting information prior to inpatient admissions and performance of selected ambulatory procedures and services. The process permits advance eligibility verification, determination of coverage, and communication with the physician and/or member. It also allows Aetna to coordinate the patient's transition from the inpatient setting to the next level of care (discharge planning), or to register patients for specialized programs like disease management, case management, or our prenatal program. In some instances, precertification is used to inform physicians, members and other health care providers about cost-effective programs and alternative therapies and treatments.

   Certain healthcare services, such as hospitalization or outpatient surgery, require precertification with Aetna to ensure coverage for those services. When a member is to obtain services requiring precertification through a participating provider, this provider should precertify those services prior to treatment. If your plan covers self-referred services to network providers, (i.e. Aetna Open Access), or out-of-network benefits and you may self-refer for covered benefits, it is your responsibility to contact Aetna to precertify those services which require precertification to avoid a reduction in benefits paid for that service.

8. Aetna will not retroactively deny covered non-emergency treatment that had prior authorization under the company's written policies.

9. **Utilization Review/Patient Management.**

   Aetna has developed a patient management program to assist in determining what health care services are covered and payable under the health plan and the extent of such coverage and payment. The program assists members in receiving appropriate health care and maximizing coverage for those health care services.

   Where such use is appropriate, our utilization review/patient management staff uses nationally recognized guidelines and resources, such as Milliman Care Guidelines© and InterQual® ISD® criteria, 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 polices may be modified to comply with applicable state law.

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

10. **Concurrent Review.**

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.

11. **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 the member upon discharge from an inpatient stay.

12. **Retrospective Record Review.**

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 and payment of health care services. Aetna's effort to manage the services provided to members includes the retrospective review of claims submitted for payment and of medical records submitted for potential quality and utilization concerns.

13. **Point of Service Plan.**

Aetna offers Point of Service (POS) plans to employers. POS plans allow members to self-refer to providers within the plan's network or to seek the services of providers who are not contracted with the plan. When members do not seek services through their PCP or on referral of their PCP, payment of a deductible and of a portion of the allowed charges (called coinsurance) is required. Certain procedures and elective hospital admissions may still require precertification by the plan.

F. 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 HMO 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 PCP. Notify your 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 PCP or Aetna as soon as possible.

What to Do Outside Your Aetna HMO Service Area.

Members who are traveling outside their Aetna service area or students who are away at school 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 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 service area, you must obtain a referral before any follow-up care can be covered. Suture removal, cast removal, X-rays and clinic and emergency room revisits are some examples of follow-up care.

G. PRESCRIPTION DRUGS

If your plan covers outpatient prescription drugs, your plan may include a drug formulary. A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan subject to applicable limitations and conditions. The medications listed on the formulary are subject to change in accordance with applicable state law. For information regarding how medications are reviewed and selected for the formulary, please refer to the Aetna Medication Formulary Guide. A printed copy of the Formulary Guide will be provided, upon request, or if applicable, annually for current members and upon enrollment for new members. Additional copies can be obtained by calling Member Services at the toll-free number listed on your member ID card, and current Formulary Guide information is available by accessing our website at **www.aetna.com**. Many drugs listed on the formulary are subject to manufacturer rebate arrangements between Aetna and the manufacturer of the drugs for the benefit of Aetna. Your pharmacy benefit is not limited to the drugs listed on the formulary. Medications that are not listed on the formulary may be covered subject to the limits and exclusions set forth in your plan documents. Covered prescription drugs not listed on the formulary may be subject to higher copayments under some benefit plans. Some pharmacy benefit plans may exclude certain drugs not listed on the formulary from coverage. If it is medically necessary for members enrolled in these benefit plans to use such drugs, their physicians (or pharmacist in the case of antibiotics and analgesics) may contact Aetna to request coverage as a medical exception. 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, depending on the benefit plan selected by your plan sponsor. Check your plan documents for details. In addition, certain drugs may require precertification or step therapy under some prescription drug benefit plans. Step therapy is a different form of precertification which requires a trial of one or more "prerequisite therapy" medications before a "step therapy" medication will be covered. If it is medically necessary for a member to use a medication subject to these requirements, the member's physician can request coverage of such drug as a medical exception. Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and conditions of coverage.

If you use the mail-order prescription program of Aetna Rx Home Delivery, LLC, you will be acquiring these prescriptions through an affiliate of Aetna.

H. BEHAVIORAL HEALTH NETWORK

In most areas, certain behavioral health services (e.g., treatment or care for mental disease or illness, alcohol abuse and/or substance abuse) are managed by an independently contracted organization. This organization makes initial coverage determinations and coordinates referrals; any behavioral health care referrals will generally be made to providers affiliated with the organization, unless your needs for covered services extend beyond the capability of these providers. You can receive information regarding the appropriate way to access the behavioral health care services that are covered under your specific plan by reviewing the information below. As with other coverage determinations, you may appeal behavioral health care coverage decisions in accordance with the terms of your health plan.

Behavioral health coverage varies depending on the plan. As a member, you may be covered for treatment of mental or behavioral conditions, and/or drug or alcohol abuse problems. You can determine the type of plan you have by calling the Aetna Member Services number on your ID card.

If you have an emergency, call 911 or your local emergency hotline, if available. However, for routine services, please note the following.

You can access behavioral health services by the following methods:

- Calling your PCP for referral to the designated behavioral health provider group.
- Being referred to your designated behavioral health provider group by your employee assistance or student assistance professional.
- Contacting Member Services at the toll-free number on your Member ID card, asking for the name and phone number of your designated behavioral health provider group, and calling that number directly.

Note: Some plan sponsors may have selected a Behavioral Health vendor other than **an Aetna Behavioral Health contractor** to manage their Behavioral Health benefits. If you have any questions regarding the name of the Behavioral Health vendor for your group, please contact Member Services at the toll-free number on your ID card. You may also contact your plan sponsor.

I. HOW AETNA COMPENSATES YOUR PHYSICIAN

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

Participating physicians in our network are compensated in various ways:

- Per individual service or case (fee for service at contracted rates).
- Per hospital day (per diem contracted rates).
- Capitation (a prepaid amount per member, per month).
- Through Integrated Delivery Systems (IDSs), Independent Practice Associations (IPAs), Physician Hospital Organizations (PHOs), Physician Medical Groups (PMGs), behavioral health organizations and similar provider organizations or groups. Aetna pays these organizations, which in turn reimburse the physician or facility directly for services by a variety of methods. In such arrangements, the group or organization has a financial incentive to control the cost of care.

  Plan providers have no requirement to comply with specified numbers, targeted averages or maximum duration for patient visits. Plan compensation arrangements are designed to encourage the provision of the most appropriate care for each patient and to discourage the provision of unnecessary, and potentially detrimental services. The Plan incorporates specific "quality factors" into the compensation process. Provider compensation is adjusted based on results in various areas, including: appropriate diagnostic testing, specialty and hospital utilization; member satisfaction survey results; thoroughness of medical chart documentation; clinical care measures for diabetes, asthma and other conditions; number of scheduled office hours; range of office procedures offered; around the clock coverage; and participation in continuing education programs. There are no plan compensation incentives or penalties that are intended to encourage providers to withhold services or to minimize or avoid referrals to specialists.

PCPs who participate in Aetna receive incentives as part of the Quality Enhancement (QE) program.

You are encouraged to ask your physicians and other providers how they are compensated for their services.

Quality Enhancement:

In some regions, the QE program rewards PCPs for their scores on several measures intended to evaluate the quality of care and services the PCPs provide to members. PCP offices can earn additional compensation for each member each month based on the scores received on one or more of the following measures of the PCP's office: member satisfaction, percentage of members who visit the office at least annually, medical record reviews, the burden of illness of the members that have selected the PCP, management of chronic illnesses like asthma, diabetes and congestive heart failure; whether the physician is accepting new patients, and participation in Aetna's electronic claims and referral submission program.

Claims Payment for Nonparticipating Providers and Use of Claims Software

If your plan provides coverage for services rendered by nonparticipating providers, you should be aware that Aetna determines the usual, customary and reasonable fee for a provider by referring to commercially available data reflecting the customary amount paid to most providers for a given service in that geographic area. If such data is not commercially available, our determination may be based upon our own data. Aetna may also use computer software (including ClaimCheck) and other tools to take into account factors such as the complexity, amount of time needed and manner of billing. You may be responsible for any charges Aetna determines are not covered under your plan.

J. MEDICAL NECESSITY

To be **medically necessary**, the service or supply must:

- be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the member's overall health condition;
- be care or services related to diagnosis or treatment of an existing illness or injury, except for covered periodic health evaluations and preventive and well-baby care, as determined by Aetna;

- be a diagnostic procedure, indicated by the health status of the member and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the member's overall health condition;
- include only those services and supplies that cannot be safely and satisfactorily provided at home, in a physician's office, on an outpatient basis, or in any facility other than a hospital, when used in relation to inpatient hospital services; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests.

In determining if a service or supply is medically necessary, Aetna will consider:

- information provided on the member's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized health care organizations that include supporting scientific data (including but not limited to Milliman & Robertson Health Care Management Guidelines©, InterQual® ISD criteria and Aetna's Coverage Policy Bulletins);
- professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;
- the opinion of health professionals in the generally recognized health specialty involved;
- the opinion of the attending physicians, which have credence but do not overrule contrary opinions; and
- any other relevant information brought to Aetna's attention.

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

All covered benefits will be covered in accordance with the guidelines determined by Aetna.

K. CLINICAL POLICY BULLETINS

Aetna's Clinical Policy Bulletins (CPBs) are used as a guide when determining health care coverage for our members. CPBs are written on selected clinical issues, especially addressing new technologies, new treatment approaches, and procedures. CPBs are based on peer-reviewed medical literature, the recommendations of leading medical organizations, and (where appropriate) the Center for Medicare & Medicaid Services' Medicare coverage policies. Some CPBs are available online at **www.aetna.com**. Because CPBs can be highly technical and are designed to be used by our professional staff making coverage determinations, members may want to review the CPBs of interest with their physician so they may fully understand them. CPBs do not constitute medical advice, and treating providers are solely responsible for medical advice and treatment of members. Actual coverage decisions are made on a case-by-case basis by Aetna. The CPB is used as a tool to be interpreted in conjunction with the member's specific benefit plan and after consultation with the treating physician. CPBs are subject to change.

L. COMPLAINT PROCEDURES

The following procedures provide the member with the guidelines that govern the Claim Determination Procedures/Complaints and Appeals/External Independent Medical Review/Dispute Resolution.

When the member's coverage is first effective, the member will receive a separate information packet that contains additional important information about how to appeal decisions made by Aetna.

Upon the subsequent renewal of the member's coverage, the member may obtain a replacement Appeal information packet by contacting Member Services at 1-800-756-7039.

During each level of the process, the member is encouraged to be as specific as possible as to the member's desired resolution. At each step in the process, the member will be informed of the next level of appeal and any relevant procedures, addresses and phone numbers.

CLAIM DETERMINATION/COMPLAINTS AND APPEALS/EXTERNAL INDEPENDENT MEDICAL REVIEW/DISPUTE RESOLUTION PROCEDURES

CLAIM DETERMINATION PROCEDURES

A claim occurs whenever a member or the member's authorized representative requests pre-authorization as required by the plan from Aetna, a referral as required by the plan from a participating provider or requests payment for services or treatment received. As an HMO member, you are not required to submit claims. However, if you receive a bill for covered benefits, the bill must be submitted promptly to Aetna for payment. Send the itemized bill for payment with your identification number clearly marked to the address shown on your ID card.

Aetna will make a decision on the member's claim. For urgent care claims and preservice claims, Aetna will send the member written notification of the determination, whether adverse or not adverse. For other types of claims, the member may only receive notice if Aetna makes an adverse benefit determination.

Adverse benefit determinations are decisions made by Aetna that result in denial, reduction, or termination of a benefit or the amount paid for it. It also means a decision not to provide a benefit or service. Adverse benefit determinations can be made for one or more of the following reasons:

- Utilization Review. Aetna determines that the service or supply is not medically necessary or is an experimental or investigational procedure;
- No Coverage. Aetna determines that a service or supply is not covered by the plan. A service or supply is not covered if it is not included in the list of covered benefits;
- It is excluded from coverage;
- An Aetna limitation has been reached; or
- Eligibility. Aetna determines that the subscriber or subscriber's covered dependents are not eligible to be covered by Aetna.

Written notice of an adverse benefit determination will be provided to the member within the following time frames. Under certain circumstances, these time frames may be extended. The notice will provide important information that will assist the member in making an Appeal of the adverse benefit determination, if the member wishes to do so. Please see the Complaints and Appeals section of the COC for more information about Appeals.

THIS DISCLOSURE FORM IS ONLY A SUMMARY.
THE PLAN'S EVIDENCE OF COVERAGE SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

Aetna Time Frame for Notification of an Adverse Benefit Determination

Type of Claim	Aetna Response Time from Receipt of Claim
Urgent Care Claim. A claim for medical care or treatment where delay could seriously jeopardize the life or health of the member, the ability of the member to regain maximum function; or subject the member to severe pain that cannot be adequately managed without the requested care or treatment.	As soon as possible but not later than 72 hours.
Preservice Claim. A claim for a benefit that requires preauthorization of the benefit in advance of obtaining medical care.	Within 15 calendar days.
Concurrent Care Claim Extension. A request to extend a course of treatment previously preauthorized by Aetna.	If an urgent care claim, as soon as possible but not later than 24 hours. Otherwise, within 15 calendar days.
Concurrent Care Claim Reduction or Termination. Decision to reduce or terminate a course of treatment previously preauthorized by Aetna.	With enough advance notice to allow the member to Appeal.
Postservice Claim. A claim for a benefit that is not a preservice claim.	[Within 15 calendar days] [Within 30 calendar days]

COMPLAINTS AND APPEALS

Aetna has procedures for members to use if they are dissatisfied with a decision that Aetna has made or with the operation of Aetna. The procedure the member needs to follow will depend on the type of issue or problem the member has.

- Appeal. An appeal is a request to Aetna to reconsider an adverse benefit determination. The appeal procedure for an adverse benefit determination has two levels.
- Complaint. A Complaint is an expression of dissatisfaction about quality of care or the operation of Aetna.

A. Complaints.

If the member is dissatisfied with the administrative services the member receives from Aetna or wants to complain about a participating provider, call or write Member Services within 30 calendar days of the incident. The member will need to include a detailed description of the matter and include copies of any records or documents that the member thinks are relevant to the matter. Aetna will review the information and provide the member with a written response within 30 calendar days of the receipt of the complaint, unless additional information is needed and it cannot be obtained within this time frame. The response will tell the member what the member needs to do to seek an additional review.

B. Appeals of Adverse Benefit Determinations.

The member will receive written notice of an adverse benefit determination from Aetna. The notice will include the reason for the decision and it will explain what steps must be taken if the member wishes to appeal. The notice will also identify the member's rights to receive additional information that may be relevant to an appeal. Requests for an appeal must be made in writing within 2 years from the date of the notice.

A member may also choose to have another person (an authorized representative) make the appeal on the member's behalf by providing Aetna with written consent. However, in case of an urgent care claim or a preservice claim, a physician may represent the member in the appeal.

Aetna provides for two levels of appeal of the adverse benefit determination. If the member decides to appeal to the second level, the request must be made in writing within 60 calendar days from the date of the notice to the following address. The following chart summarizes some information about how the appeals are handled for different types of claims.

THIS DISCLOSURE FORM IS ONLY A SUMMARY.
THE PLAN'S EVIDENCE OF COVERAGE SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

Name: Aetna Health Inc./Corporate Health Insurance Company
Title: Medical Resolution Team
Address: P.O. Box 14596, Lexington, KY 40512
Phone: 1-800-305-7342
Fax: 1-818-932-6566

Aetna Time Frame for Notification of an Adverse Benefit Determination

Type of Claim	Level One Appeal Aetna Response Time from Receipt of Appeal	Level Two Appeal Aetna Response Time from Receipt of Appeal
Urgent Care Claim. A claim for medical care or treatment where delay could seriously jeopardize the life or health of the member, the ability of the member to regain maximum function; or subject the member to severe pain that cannot be adequately managed without the requested care or treatment.	1 business day or 36 hours from receipt, whichever is less. Review provided by Aetna personnel not involved in making the adverse benefit determination.	Within 36 hours. Review provided by Aetna Appeals Committee.
Preservice Claim. A claim for a benefit that requires approval of the benefit in advance of obtaining medical care.	Within 15 calendar days. Review provided by Aetna personnel not involved in making the adverse benefit determination.	Within 15 calendar days. Review provided by Aetna Appeals Committee.
Concurrent Care Claim Extension. A request to extend or a decision to reduce a previously approved course of treatment.	Treated like an urgent care claim or a preservice claim depending on the circumstances.	Treated like an urgent care claim or a preservice claim depending on the circumstances.
Postservice Claim. Any claim for a benefit that is not a preservice claim.	Within 30 calendar days. Review provided by Aetna personnel not involved in making the adverse benefit determination.	Within 30 calendar days. Review provided by Aetna Appeals Committee.

A member and/or an authorized representative may attend the Level-Two Appeal hearing and question the representative of Aetna and/or any other witnesses and present their case. The hearing will be informal. A member's physician or other experts may testify. Aetna also has the right to present witnesses.

C. External Independent Medical Review.

1. Eligibility

   The member may obtain external independent medical review only after the member has sought any appeals through standard levels one (informal reconsideration) and two (formal) appeal above or through expedited medical review. The member has 30 days after receipt of written notice from Aetna that the member's formal appeal or expedited medical review has been denied to request external independent medical review. Neither the member nor the member's treating provider is responsible for the cost of any external independent medical review. The member must send a written request for external independent medical review and any material justification or documentation to support the member's request for the covered service or claim for a covered service to:

   Name: Aetna Health Inc./Corporate Health Insurance Company

   Title: Medical Resolution Team
   Address: P.O. Box 14596, Lexington, KY 40512
   Phone: 1-800-305-7342
   Fax: 1-818-932-6566

2. Process: There are 2 types of external independent medical review appeals, depending on the issues in the member's case:

   a. Medical necessity appeals are cases where Aetna has decided not to authorize a service because Aetna believes the service(s) the member or the member's treating provider are asking for, are not medically necessary to treat the member's condition. The external independent reviewer is a provider retained by an outside independent review organization (IRO), that is procured by the Arizona Insurance Department, and not connected with Aetna. The IRO provider must be one who typically manages the condition under review.

      Within 5 business days of receiving the member's or the Director of Insurance's request, or if Aetna initiates an external independent medical review, Aetna must:

      - Mail a written acknowledgement to the Director of Insurance, the member, and the member's treating provider.

      - Send the Director of Insurance: the request for review; the member's COC; all medical records and supporting documentation used to render Aetna's decision; a summary of the applicable issues including a statement of Aetna's decision; the criteria used and clinical reasons for Aetna's decision; and the relevant portions of Aetna's utilization review guidelines. We must also include the name and credentials of the provider who reviewed and upheld the denial at the earlier appeal levels.

      Within 5 business days of receiving Aetna's information, the Director of Insurance must send all the submitted information to an expedited, IRO.

      Within 21 business days of receiving the information, the IRO must make a decision and send the decision to the Director of Insurance.

      Within 5 business days of receiving the IRO's decision, the Director of Insurance will mail a notice of the decision to Aetna, the member, and the member's treating provider.

   b. Contract coverage issues are appeals where Aetna has denied coverage because Aetna believes the requested service is not covered under the member's COC. For these appeals, the Arizona Insurance Department is the external independent reviewer.

      Within 5 business days of receiving the member's request or if Aetna initiates an external independent medical review, Aetna must:

      - Mail a written acknowledgement of the member's request to the Director of Insurance, the member, and the member's treating provider.

      - Send the Director of Insurance: the request for review, the member's COC; all medical records and supporting documentation used to render Aetna's decision; a summary of the applicable issues including a statement of Aetna's decision, the criteria used and any clinical reasons for our decision and the relevant portions of Aetna's utilization review guidelines.

Within 15 business days of receiving this information, the Director of Insurance will determine if the service or claim is covered, issue a decision, and send a notice of determination to Aetna, the member, and the member's treating provider.

The Director of Insurance is sometimes unable to determine issues of coverage. If this occurs or if the Director of Insurance finds that the case involves a medical issue, the Director of Insurance will forward the member's case to an IRO. The IRO will have 21 business days to make a decision and send it to the Director of Insurance. The Director of Insurance will have 5 business days after receiving the IRO's decision to send the decision to Aetna, the member, and the member's treating provider.

3. Decision

   Medical Necessity Decision:

   If the IRO decides that Aetna should provide the service, Aetna must authorize the service regardless of whether judicial review is sought. If the IRO agrees with Aetna's decision to deny the service, the appeal is over. The member's only further option is to pursue the member's claim in Superior Court. However, on written request by the IRO, the member or Aetna, the Director of Insurance may extend the 21-day time period for up to an additional 30 days, if the requesting party demonstrates good cause for an extension.

   Contract Coverage Decision:

   If the member disagrees with the Insurance Director's final decision on a contract coverage issue, the member may request a hearing with the Office of Administrative Hearings (OAH). If Aetna disagrees with the Director's final decision, Aetna may also request a hearing before the OAH. A hearing must be requested within 30 days of receiving the coverage issue determination. OAH has rules that govern the conduct of their hearing proceedings.

Expedited Appeals Process For Urgently Needed Services The Member Has Not Yet Received

A. Expedited Medical Review (Level One).

1. Eligibility

   The member may obtain Expedited Medical Review of the denied request for a covered service that has not already been provided if:

   - The member has coverage with Aetna,
   - Aetna has denied the member's request for a covered service, and
   - The member's physician or treating Provider certifies in writing and provides supporting documentation that the time required to process the member's request through the standard informal reconsideration process described above and standard formal appeal process described above is likely to cause a significant negative change in the member's medical condition. This certification is not challengeable by Aetna.

   The member's treating provider must send the certification and documentation to:

Name:	Aetna Health Inc./Corporate Health Insurance Company
Title:	Medical Resolution Team
Address:	P.O. Box 14596, Lexington, KY 40512
Phone:	1-800-305-7342
Fax:	1-818-932-6566

2. Decision

   Aetna has 1 business day after Aetna receives the information from the member's treating provider to decide whether Aetna should change their decision and authorize the member's requested service. Within that same business day, Aetna must mail to the member and the member's treating provider Aetna's decision in writing. Notice of the decision will include criteria used to make the decision, clinical reasons for the decision, and any references to supporting documentation.

   If the member's appeal is an issue of medical necessity, before making the decision, Aetna will consult with a:

   Physician or other appropriate licensed health care professional, or

An out-of-state provider, physician or other health care professional who is licensed in another state and who is not licensed in Arizona and who typically manages the member's medical condition under review.

a. Denial Upheld

If Aetna agrees that the covered service should have been denied, Aetna will telephone the member and the member's treating provider and will mail to the member and the member's treating provider a notice of the adverse decision and of the member's option to immediately proceed to an expedited appeal level-two appeal.

b. Denial Reversed

If Aetna agrees that the covered service should have been provided, Aetna must authorize the service and the member's appeal is ended.

B. Expedited Appeal (Level Two).

1. Eligibility

If Aetna denies a member's request at expedited medical review level one for a covered service that has not already been provided, the member may request an expedited appeal. After the member receives Aetna's level-one denial, the member's treating provider must immediately send a written request to Aetna (to the same person and address listed above under Level One to notify Aetna that the member is appealing to level-two appeal. The member's treating provider may want to send any additional information, not previously submitted to Aetna, to support the member's request for the service.

2. Process

Medically necessary appeal decisions will be made by any provider who is qualified in a scope of practice similar to that of the treating provider, or one who typically manages the medical condition under appeal. Aetna will select the provider who shall review the appeal and render the decision.

Coverage issue appeal decisions are not required to be rendered by a participating provider.

3. Decision

Aetna has 3 business days after receipt of the request for an expedited appeal level-two appeal. to notify the member and the member's treating provider of the decision.

a. Denial Upheld

If Aetna agrees that the covered service should have been denied, the member may immediately appeal to external independent medical review. Aetna will telephone the member and the member's treating provider and will mail to the member and the member's treating provider a notice of the denial and of the member's option to immediately proceed to expedited external independent review.

b. Denial Reversed

If Aetna agrees that the covered service should have been provided, Aetna must authorize the service and the member's appeal is ended.

c. Aetna may decide to skip level-two appeal and send the member's case straight to expedited external independent review. Aetna must send the member and the member's treating provider a written acknowledgment that the appeal was submitted for expedited external independent medical review.

C. Expedited External Independent Medical Review.

1. Eligibility

The member may appeal to expedited external independent medical review only after the member has appealed through level one. The member has 5 business days after the member receives Aetna's level one decision to send Aetna the member's written request for expedited external independent medical review. The member's request should include any additional information to support the member's request for the service. The member and the member's treating provider are not responsible for the cost of any expedited external independent medical review.

The member should send the request and any additional supporting information to:

Name:	Aetna Health Inc./Corporate Health Insurance Company
Title:	Medical Resolution Team
Address:	P.O. Box 14596, Lexington, KY 40512
Phone:	1-800-305-7342
Fax:	1-818-932-6566

2. Process: There are 2 types of expedited external independent medical review appeals, depending on the issues in the member's case:

   a. Medical necessity appeals are cases where Aetna has decided not to authorize a service because Aetna believes the service(s) the member or the member's treating provider are asking for, are not medically necessary to treat the member's condition. The expedited external independent reviewer is a provider retained by an outside IRO that is procured by the Arizona Insurance Department and not connected with Aetna. The IRO provider must be a provider who typically manages the condition under review.

      Within 1 business day of receiving the member's request, Aetna must:

      - Mail a written acknowledgement of the request to the Director of Insurance, the member, and the member's treating provider.
      - Send the Director of Insurance: the request for review; the member's COC; all medical records and supporting documentation used to render Aetna's decision; a summary of the applicable issues, including a statement of Aetna's decision, the criteria used and clinical reasons for Aetna's decision, and the relevant portions of Aetna's utilization review guidelines. Aetna must also include the name and credentials of the provider who reviewed and upheld the denial at the earlier appeal levels.

      Within 2 business days of receiving Aetna's information, the Director of Insurance must send all the submitted information to an expedited, external IRO.

      Within 5 business days of receiving the information, the IRO must make a decision and send the decision to the Insurance Director.

      Within 1 business day of receiving the IRO's decision, the Insurance Director must mail a notice of the decision to Aetna, the member, and the member's treating provider.

   b. Contract coverage issues are appeals where Aetna has denied coverage because Aetna believes the requested service is not covered under the member's COC. For these appeals, the Arizona Insurance Department is the expedited external independent reviewer.

      Within 1 business day of receiving the Member's request, Aetna must:

      - Mail a written acknowledgement of the member's request to the Insurance Director, the member, and the member's treating provider.
      - Send the Director of Insurance: the request for review, the member's COC; all medical records and supporting documentation used to render Aetna's decision; a summary of the applicable issues, including a statement of Aetna's decision, the criteria used and any clinical reasons for Aetna's decision and the relevant portions of Aetna's utilization review guidelines.

      Within 2 business days of receiving this information, the Insurance Director must determine if the service or claim is covered, issue a decision, and send a notice to Aetna, the member, and the member's treating provider.

      The Director of Insurance is sometimes unable to determine issues of coverage. If this occurs, the Director of Insurance will forward the member's case to an IRO. The IRO will have 5 business days to make a decision and send it to the Insurance Director. The Insurance Director will have 1 business day after receiving the IRO's decision to send the decision to Aetna, the member, and the member's treating provider.

3. Decision

   Medical Necessity Decision:

   If the IRO decides that Aetna should provide the service, Aetna must authorize the service. If the IRO agrees with Aetna's decision to deny the service, the appeal is over. The member's only further option is to pursue the member's claim in Superior Court.

Contract Coverage Decision:

If the member disagrees with the Insurance Director's final decision on a contract coverage issue, the member may request a hearing with the OAH. If Aetna disagrees with the Director's final decision, Aetna may also request a hearing before the OAH. A hearing must be scheduled within 30 days of receiving the Director's decision. OAH must promptly schedule and complete a hearing for appeals from expedited external independent medical review appeals decisions.

D. The Role of the Director of Insurance.

Arizona law (A.R.S. §20-2533(F)) requires "any member who files a complaint or appeal with the Department relating to an adverse decision to pursue the review process prescribed" by law. This means, that for decisions that are appealable, the member must pursue the health care appeals process before the Director of Insurance can investigate a complaint or appeal the member may have against Aetna based on the decision at issue in the appeal.

The appeal process requires the Director to:

1. Oversee the appeals process.
2. Maintain copies of each utilization review plan submitted by Aetna.
3. Receive, process, and act on requests from Aetna for external independent medical review.
4. Enforce the decisions of Aetna.
5. Review decisions of Aetna.
6. Report to the Legislature.
7. Send, when necessary, a record of the proceedings of an appeal to Superior Court or to the OAH.
8. Issue a final administrative decision on coverage issues, including the notice of the right to request a hearing at the OAH.

E. Obtaining Medical Records.

Arizona law (A.R.S. §12-2293) permits the member to ask for a copy of their medical records. The member's request must be in writing and must specify who the member wants to receive the records. The health care provider who has the member's records will provide the member or the person the member specifies with a copy of the member's records.

Designated Decision Maker: If the member has a designated health care decision maker, that person must send a written request for access to or copies of the member's medical records. The medical records must be provided to the member's health care decision maker or a person designated in writing by the member's health care decision maker unless the member limits access to the member's medical records only to the member or the member's health care decision maker.

Confidentiality: Medical records disclosed under A.R.S. §12-2293 remain confidential. If the member participates in the appeal process, the relevant portions of the member's medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose the member's medical information to any other people.

F. Documentation for an Appeal.

If the member decides to file an appeal, the member must give us any material justification or documentation for the appeal at the time the appeal is filed. If the member gathers new information during the course of the member's appeal, the member should give it to Aetna as soon as the member receives it. The member must also give Aetna the address and phone number where the member can be contacted. If the appeal is already at expedited external independent medical review, the member should also send the information to the Department.

G. Receipt of Documents.

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed (the member's last known address) on the fifth business day after being mailed.

H. Record Retention.

Aetna shall retain the records of all complaints and appeals for a period of at least 7 years.

I. Fees and Costs.

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.

DISPUTE RESOLUTION

Any controversy, dispute or claim between Aetna on the one hand and one or more interested parties on the other hand arising out of or relating to the Group Agreement or Group Policy, whether stated in tort, contract, statute, claim for benefits, bad faith, professional liability or otherwise ("Claim"), shall be settled by confidential binding arbitration administered by the American Arbitration Association ("AAA") before a sole arbitrator ("Arbitrator"). Judgment on the award rendered by the Arbitrator ("Award") may be entered by any court having jurisdiction thereof. If the AAA declines to administer the case and the parties do not agree on an alternative administrator, a sole neutral arbitrator shall be appointed upon petition to a court having jurisdiction. Aetna and Interested Parties hereby give up their rights to have Claims decided in a court before a jury.

Any Claim alleging wrongful acts or omissions of participating or nonparticipating providers shall not include Aetna. A member must exhaust all complaint, appeal and independent external review procedures prior to the commencement of arbitration hereunder. No person may recover any damages arising out of or related to the failure to approve or provide any benefit or coverage beyond payment of or coverage for the benefit or coverage where (i) Aetna has made available independent external review and (ii) Aetna has followed the reviewer's decision. Punitive damages may not be recovered as part of a Claim under any circumstances. No Interested Party may participate in a representative capacity or as a member of any class in any proceeding arising out of or related to the Group Agreement or Group Policy. This agreement to arbitrate shall be specifically enforced even if a party to the arbitration is also a party to another proceeding with a third party arising out of the same matter.

M. CONFIDENTIALITY

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 a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care to the member. 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 the member.

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), payers (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 member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at **www.aetna.com**.

N. DESCRIPTION OF BENEFITS - RENEWABILITY OF COVERAGE

1. Covered Benefits.
   A. Primary Care Physician Benefits.
      1. Office visits during office hours.
      2. Home visits/After-hours.
      3. Hospital visits.
      4. Periodic health evaluations to include:
         a. well-child care from birth;
         b. routine physical examinations;
         c. routine gynecological examinations;
         d. routine hearing screenings;
         e. immunizations;
         f. routine vision screenings.

      Periodic health evaluations will be provided when medically necessary or at least as often as shown below:

Member's Age	Exam Frequency
0 - 1 year	1 exam every 4 months
2 - 5 years	1 exam every year
6 - 40 years	1 exam every 5 years
41 - 50 years	1 exam every 3 years
51 - 60 years	1 exam every 2 years
61 years and over	1 exam every year

      Additionally, a medical history and health examination will be offered to each new member within 12 months after enrollment.
      5. Injections, including allergy desensitization injections.
      6. Casts and dressings.
      7. Health education counseling and information.

   B. Diagnostic Services Benefits.

      Services include the following:
      1. Diagnostic, laboratory, and x-ray services.
      2. Mammograms

      Screening mammogram benefits for female members are provided as follows:
      - age 35 through 39, one baseline mammogram;
      - age 40 and older, 1 routine mammogram every year; or
      - when medically necessary.

   C. Specialist Physician Benefits, including outpatient and inpatient services.
   D. Direct Access Specialist Benefits.

      The following services are covered without a referral when rendered by a participating provider.
      - Routine gynecological examination(s).
      - Direct access to gynecologists.
      - Routine eye examinations
      - Preventive dental care for members under the age of 12. See your Summary of Benefits for plan applicability

   E. Maternity Care and Related Newborn Care Benefits.
   F. Inpatient Hospital and Skilled Nursing Facility Benefits.
   G. Transplants Benefits.
   H. Outpatient Surgery Benefits.
   I. Substance Abuse Benefits (inpatient/outpatient services for detoxification).
   J. Mental Health Benefits.
   K. Emergency Care/Urgent Care Benefits.
   L. Outpatient Rehabilitation Benefits.
   M. Home Health Benefits.
   N. Hospice Benefits.
   O. Prosthetic Appliances Benefits.
   P. Injectable Medications Benefits.
   Q. Basic Infertility Services Benefits.
   R. Diabetes Services.
   S. Blood and Blood Plasma.
   T. Reconstructive Breast Surgery Services.
   U. Chiropractic Benefits.

   Depending upon your employer's chosen plan of benefits, there may be other benefits added to your plan as riders.
2. See your attached Summary of Benefits for copayment information.
3. Services are covered outside the plan in the event of an emergency. See Emergency Care.

O. RENEWABILITY OF COVERAGE

1. Termination of Subscriber Coverage.
   A. A subscriber's coverage will terminate for any of the following reasons:
      1. employment terminates;
      2. the Group Agreement terminates;
      3. the subscriber is no longer eligible as outlined on the Schedule of Benefits; or
      4. the subscriber becomes covered under an alternative health benefit plan or under any other plan which is offered by, through, or in connection with the contract holder in lieu of coverage under the COC.
2. Termination of Dependent Coverage.
   A. A covered dependent's coverage will terminate for any of the following reasons:
      1. a covered dependent is no longer eligible, as outlined on the Schedule of Benefits;
      2. the Group Agreement terminates; or
      3. the subscriber's coverage terminates.
3. Termination For Cause.
   A. Aetna may terminate coverage for cause upon 60 days written notice:
      1. if the member has failed to make any required premium payment which the member is obligated to pay. Upon the effective date of such termination, prepayments received by Aetna on account of such terminated member or members for periods after the effective date of termination shall be refunded to contract holder.
      2. upon discovering a material misrepresentation by the contract holder in applying for or obtaining coverage or benefits or discovering that the contract holder has committed fraud against Aetna.

P. LIMITATIONS AND EXCLUSIONS THAT APPLY TO SERVICES AND BENEFITS

This section lists some, but not all, benefits and services that are not covered services under the COC. Members are advised to carefully review the entire COC, including the covered benefits section, and any applicable riders, to determine the extent of a particular benefit's coverage. The following are some, but not all, examples of limitations and excluded services and supplies for which a member is not covered under the COC:

- Ambulance services, for routine transportation to receive outpatient or inpatient services.
- Beam neurologic testing.
- Biofeedback, except as preauthorized by Aetna.
- Blood and blood plasma, including provision of blood, blood plasma, blood derivatives, synthetic blood or blood products other than blood derived clotting factors, the collection or storage of blood plasma, the cost of receiving the services of professional blood donors, apheresis or plasmapheresis. Only administration, processing of blood, processing fees, and fees related to autologous blood donations are covered.
- Care for conditions that state or local laws require to be treated in a public facility, including mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- Cosmetic surgery, or treatment relating to the consequences of, or as a result of, cosmetic surgery, other than medically necessary services. This exclusion includes surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty, except when determined to be medically necessary by an Aetna medical director, is not covered. This exclusion does not apply to surgery to correct the results of injuries causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including cleft lip and cleft palate, and postmastectomy reconstruction.
- Costs for services resulting from the commission of or attempt to commit a felony by the member.
- Court ordered services or those required by court order as a condition of parole or probation.
- Custodial care.
- Dental services, including services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, dental services related to the gums, apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, alveolectomy, augmentation and vestibuloplasty treatment of periodontal disease, false teeth, prosthetic restoration of dental implants, and dental implants. This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors, and orthodontogenic cysts.

- Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, learning disabilities, or developmental delays. Special education, including lessons in sign language to instruct a member, whose ability to speak has been lost or impaired, to function without that ability, is not covered.
- Experimental or investigational procedures, or ineffective surgical, medical, psychiatric, or dental treatments or procedures, research studies, or other experimental or investigational health care procedures or pharmacological regimens as determined by Aetna, unless preauthorized by Aetna.

  This exclusion will not apply with respect to drugs:

  1. that have been granted treatment investigational new drug (IND) or Group c/treatment IND status;
  2. that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or
  3. Aetna has determined that available scientific evidence demonstrates that the drug is effective or the drug shows promise of being effective for the disease.

  This exclusion will also not apply to the following:

  Aetna will provide coverage for all medically necessary routine patient care costs incurred as a result of a treatment being provided in accordance with a cancer clinical trial in which a member participates voluntarily, except to the extent that the expenses are paid by the government, biotechnical, pharmaceutical or medical device industry sources.

  All of the following apply to a course of treatment for a cancer clinical trial:

  1. The treatment is part of a scientific study of a new therapy or intervention that is being conducted at an institution in Arizona for the treatment, palliation or prevention of cancer in humans;
  2. The treatment is provided as part of a study being conducted in a phase I, phase II, phase III or phase IV cancer clinical trial;
  3. The treatment is provided as part of a study being conducted in accordance with a clinical trial approved by at least one of the following:
     a) One of the National Institutes of Health (NIH);
     b) An NIH cooperative group or center;
     c) The United States Food and Drug Administration (FDA) in the form of an investigational new drug application;
     d) The United States Departments of Defense and Veterans Affairs;
     e) A panel of qualified recognized experts in clinical research within academic health institutions in Arizona; or
     f) A qualified research entity that meets the criteria established by the NIH for grant eligibility.
  4. The proposed treatment or study has been reviewed and approved by an institutional review board of an institution in Arizona;
  5. The personnel providing the treatment or conducting the study are doing so within their scope of practice, experience and training and are capable of providing the treatment because of their experience, training and volume of patients treated to maintain expertise;
  6. There is no clearly superior, noninvestigational treatment alternative; and
  7. The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as any noninvestigational alternative.
- Hair analysis.
- Hearing aids.
- Home births.
- Home uterine activity monitoring.
- Household equipment, including the purchase or rental of exercise cycles, water purifiers, hypoallergenic pillows, mattresses or waterbeds, whirlpool or swimming pools, exercise and massage equipment, central or unit air conditioners, air purifiers, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a member's house or place of business, and adjustments made to vehicles.

- Hypnotherapy, except when preauthorized by Aetna.
- Implantable drugs.
- The treatment of male or female Infertility including:
  1. The purchase of donor sperm and any charges for the storage of sperm;
  2. The purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers;
  3. Charges associated with cryopreservation or storage of cryopreserved embryos (e.g., office, Hospital, ultrasounds, laboratory tests);
  4. Home ovulation prediction kits;
  5. Injectable infertility medications, including menotropins, hCG, GnRH agonists, and IVIG;
  6. Artificial insemination, in vitro fertilization (IVF), gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), and intracytoplasmic sperm injection (ICSI), and any other advanced reproductive technology (ART) procedures or services related to such procedures;
  7. Any charges associated with care required for ART (e.g., office, Hospital, ultrasounds, laboratory tests);
  8. Donor egg retrieval or fees associated with donor egg programs, including fees for laboratory tests;
  9. Any charges associated with a frozen embryo transfer, including thawing charges;
  10. Reversal of sterilization surgery; and
  11. Any charges associated with obtaining sperm for any ART procedures.
- Military service related diseases, disabilities or injuries for which the member is legally entitled to receive treatment at government facilities and which facilities are reasonably available to the member.
- Missed appointment charges.
- Nonmedically necessary services, including those services and supplies:
  1. which are not medically necessary, as determined by Aetna, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services;
  2. that do not require the technical skills of a medical, mental health or dental professional;
  3. furnished mainly for the personal comfort or convenience of the member, or any person who cares for the member, or any person who is part of the member's family, or any provider;
  4. furnished solely because the member is an inpatient on any day in which the member's disease or injury could safely and adequately be diagnosed or treated while not confined;
  5. furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.
- Orthotics except when applied to diabetes-related care, supplies and treatment.
- Outpatient supplies, including outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings, and reagent strips. This exclusion does not apply to diabetes-related care, supplies and treatment.
- Payment for that portion of the benefit for which Medicare or another party is the primary payer.
- Personal comfort or convenience items, including those services and supplies not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other like items and services.
- Prescription or nonprescription drugs and medicines, except when applied to diabetes-related care, supplies and treatment.

- Private duty or special nursing care, unless preauthorized by Aetna.
- Recreational, educational, and sleep therapy, including any related diagnostic testing.
- Rehabilitation services, for substance abuse, including treatment of chronic alcoholism or drug addiction.
- Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling, and sex therapy.
- Reversal of voluntary sterilizations, including related follow-up care and treatment of complications of such procedures.
- Routine foot/hand care, including routine reduction of nails, calluses and corns.
- Services for which a member is not legally obligated to pay in the absence of this coverage.
- Services for the treatment of sexual dysfunctions or inadequacies, including therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Services, including those related to pregnancy, rendered before the effective date or after the termination of the member's coverage, unless coverage is continued under the Continuation and Conversion section of the COC.
- Services performed by a relative of a member for which, in the absence of any health benefits coverage, no charge would be made.
- Services required by third parties, including physical examinations and immunizations, except when medically necessary or indicated, and diagnostic procedures, in connection with:
  1. obtaining or continuing employment;
  2. securing insurance coverage; or
  3. school admissions or attendance, including examinations required to participate in athletics, except when such examinations are considered to be part of an appropriate schedule of wellness services.
- Services that are not a covered benefit under the COC, even when a prior referral has been issued by a PCP.
- Specific nonstandard allergy services and supplies, including skin titration (wrinkle method), cytotoxicity testing (Bryan's Test), treatment of nonspecific candida sensitivity, and urine autoinjections.
- Specific injectable drugs, except when applied to diabetes-related care, supplies and treatment, including:
  1. experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the FDA and the NIH;
  2. needles, syringes and other injectable aids;
  3. drugs related to the treatment of noncovered services; and
  4. drugs related to the treatment of Infertility, contraception, and performance-enhancing steroids.
- Special medical reports, including those not directly related to treatment of the member, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
- Surgical operations, procedures or treatment of obesity, except when preauthorized by Aetna.
- Therapy or rehabilitation, including primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, vision perception training, and carbon dioxide.
- Thermograms and thermography.
- Transsexual surgery, sex change or transformation, including any procedure or treatment or related service designed to alter a member's physical characteristics from the member's biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.
- Treatment in a federal, state, or governmental entity, including care and treatment provided in a nonparticipating Hospital owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.
- Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded members in accordance with the benefits provided in the Covered Benefits section of the COC.

- Treatment of occupational injuries and occupational diseases, including those injuries that arise out of (or in the course of) any work for pay or profit, or in any way results from a disease or injury which does. If a member is covered under a Workers' Compensation law or similar law, and submits proof that the member is not covered for a particular disease or injury under such law, that disease or injury will be considered "nonoccupational" regardless of cause.
- Unauthorized services, including any service obtained by or on behalf of a member without a referral issued by the member's PCP or preauthorized by Aetna. This exclusion does not apply in a medical emergency, in an urgent care situation, or when it is a direct access benefit.
- Vision care services and supplies except as provided in the Description of Benefits - Renewability of Coverage section.
- Weight reduction programs, or dietary supplements.
- Acupuncture and acupuncture therapy, except when performed by a participating physician as a form of anesthesia in connection with covered surgery.
- Durable Medical Equipment, except when applied to diabetes-related care, supplies and treatment.
- Family planning services.
- Temporomandibular joint disorder treatment (TMJ), including treatment performed by prosthesis placed directly on the teeth, surgical and nonsurgical medical and dental services, and diagnostic or therapeutics services related to TMJ.

A. Limitations.

- In the event there are 2 or more alternative medical services which in the sole judgment of Aetna are equivalent in quality of care, Aetna reserves the right to provide coverage only for the least costly medical service, as determined by Aetna, provided that Aetna pre-authorizes the medical service or treatment.
- Determinations regarding eligibility for benefits, coverage for services, benefit denials and all other terms of the COC are at the sole discretion of Aetna, subject to the terms of the COC.

THIS DISCLOSURE FORM IS ONLY A SUMMARY.
THE PLAN'S EVIDENCE OF COVERAGE SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

Aetna Health Inc.
Arizona
Aetna HMO Plan

PLAN FEATURES	In-Network (Referred Coverage)
FINANCIAL	
Maximum Out of Pocket	$1,500-Individual/$3000-Family
Plan Deductible: Individual / Family Limit	$100-Individual/$300-Family
Coinsurance	N/A
Coinsurance Limit: Single / Family	N/A
Lifetime Maximum Benefit	N/A
PHARMACY DEDUCTIBLE Individual / Family Limit	N/A
PHYSICIAN (PCP) OFFICE VISITS	
Office Hours	$25 copay
After Hours / Home Visits	$30 copay
SPECIALTY CARE	
Office Visits	$25 copay
Diagnostic Outpatient Lab / X-rays / Testing *(At facility)*	$25 copay with PCP referral
Diagnostic Outpatient Lab / X-rays / Testing *(At specialist)*	Included in Specialist Office Visit copay for visit with PCP referral
Outpatient Therapy *(Physical, occupational or speech)*	$25 copay; Treatment over a 60-day consecutive period per incident of illness or injury beginning with the first day of treatment
Outpatient Dialysis/Chemotherapy	$25 copay
Allergy Testing/Treatment	$25 copay for testing. $25 copay for allergy injection in PCP office. No serum copay.
PREVENTIVE CARE	
Routine Physicals	$25 copay
Routine Child and Well Baby Care; Including immunizations	$25 copay
Routine GYN Care	$25 copay. One routine GYN visit and pap smear/365 days. Direct access to participating providers
Routine Mammography	$25 copay; One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over.
Routine Eye Exam	$25 copay. Direct access to participating providers; Frequency and Age Schedules may apply
Hearing Exam	$25 copay. Routine hearing screenings.
Hearing Aids	Not covered
EMERGENCY ROOM *(Copay waived if admitted)*	$200 copay
URGENT CARE	$200 copay
AMBULANCE *(Not covered as routine transportation)*	No Copay
OUTPATIENT SURGERY	$50 copay
INPATIENT HOSPITAL SERVICES	$100 copay

Sample

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THE PLAN'S EVIDENCE OF COVERAGE SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

PLAN FEATURES	In-Network (Referred Coverage)
SKILLED NURSING FACILITY *(in lieu ofhospitalization for medically necessary covered benefits)*	$100 copay
MATERNITY	
First Ob/Gyn Visit	$25 copay for initial visit only.
Inpatient Hospital Services	$100 copay
HOME HEALTH CARE	No Copay
PRIVATE DUTY or SPECIAL DUTY NURSING	Not covered unless pre-authorized by HMO; no copay when covered
HOSPICE - INPATIENT	$100 copay
HOSPICE - OUTPATIENT	No copay
FAMILY PLANNING/REPRODUCTIVE SERVICES Sterilization Procedures	Covered with applicable specialist, outpatient surgery or inpatient hospital copay. Reversal of voluntary sterilization including related follow-up care and treatment of complications of such procedures is not covered.
MENTAL HEALTH	
Inpatient *(30 days per calendar year)*	$100 copay
Outpatient *(20 visits per calendar year)*	$25 copay
SUBSTANCE ABUSE DETOXIFICATION	
Inpatient Detoxification	$100 copay
Outpatient Detoxification	$25 copay
SUBSTANCE ABUSE REHABILITATION	
Inpatient *(30 days per calendar year)*	$100 copay
Outpatient *(20 visits per calendar year)*	$25 copay
DIABETIC SUPPLIES	RX copay if RX rider purchased; otherwise PCP copay applies
CHIROPRACTIC CARE	$25 copay; Limited to 20 visits per calendar year No PCP referral needed. Requires direct access to medically necessary chiropractic services
DURABLE MEDICAL EQUIPMENT	No copay
PRESCRIPTION DRUG RIDER	$10 copay generic formulary; $30 copay brand formulary; $60 copay
No Mandatory Generics	generic and brand non-formulary; up to 30 day supply.

31 - 90 day supply included for Mail Order Delivery (MOD) - 2 times the 30 day supply.
Open formulary - Covers drugs on the formulary exclusion list.

ADDITIONAL PHARMACY OPTIONS	
Contraceptive Option	Included in Prescription Drug Option
Performance Option	Included in Prescription Drug Option
DENTAL	Not Covered
VISION CORRECTIVE LENSES/CONTACTS ALLOWANCE	Not Covered
ADVANCED REPRODUCTIVE TECHNOLOGY Available In-network only to groups with 500+ employees	Not Covered
MEDICAL SPENDING FUND Individual/Family Limits	Not Available

Sample

THIS DISCLOSURE FORM IS ONLY A SUMMARY.
THE PLAN'S EVIDENCE OF COVERAGE SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

What's Not Covered
Exclusions and Limitations

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

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Blood and blood byproducts, except as administered on an inpatient or emergency care basis.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval.
- Durable Medical Equipment.
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Hearing aids.
- Home births.
- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectible drugs including injectible infertility drugs.
- Infertility services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services unless specifically listed as covered in your plan documents.
- Long-term rehabilitation therapy.
- Nonmedically necessary services or supplies.
- Orthotics except when applied to Diabetes-related care, supplies and treatment.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies, counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Treatment of behavioral disorders.

In Arizona, benefits are provided by Aetna Health Inc. for HMO plans.

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee any results or outcomes. Consult the plan documents Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Group Policy to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan. The availability of a plan or program may vary by geographic service area. Some benefits are subject to limitations or visit maximums. Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law. Certain primary care providers are affiliated with integrated delivery systems or other provider groups (such as independent practice associations and physician-hospital organizations), and members who select these providers will generally be referred to specialists and hospitals within those systems or groups. However, if a system or group does not include a provider qualified to meet member's medical needs, member may request to have services provided by non-system or non-group providers. Member's request will be reviewed and will require prior authorization from the system or group and/or Aetna to be a covered benefit. While this material is believed to be accurate as of the print date, it is subject to change.

Sample

THIS DISCLOSURE FORM IS ONLY A SUMMARY.
THE PLAN'S EVIDENCE OF COVERAGE SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

PLAN FEATURES	Out-of-Network (Non-Referred Coverage)
FINANCIAL	
Maximum Out of Pocket	
Plan Deductible: Individual / Family Limit	$300-Individual/$900-Family
Coinsurance	60%
Coinsurance Limit: Single / Family	$4,000-Individual/$8,000-Family
Lifetime Maximum Benefit	$1,000,000
PHYSICIAN (PCP) OFFICE VISITS	
Office Hours	60% after deductible
After Hours / Home Visits	60% after deductible
SPECIALTY CARE	
Office Visits	60% after deductible
Diagnostic Outpatient Lab / X-rays / Testing *(At facility)*	60% after deductible
Diagnostic Outpatient Lab / X-rays / Testing *(At specialist)*	60% after deductible
Outpatient Therapy *(Physical, occupational or speech)*	60% after deductible
Outpatient Dialysis/Chemotherapy	60% after deductible
Allergy Testing/Treatment	60% after deductible
PREVENTIVE CARE	
Routine Physicals	Not covered unless optional preventive care rider is purchased.
Routine Child and Well Baby Care; Including immunizations	Not covered unless optional preventive care rider is purchased.
Routine GYN Care	Not covered unless optional preventive care rider is purchased.
Routine Mammography	60% after deductible; One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over.
Routine Eye Exam	Not covered
Hearing Exam	60% after deductible for illness or injury.
Hearing Aids	Not covered
EMERGENCY ROOM *(Copay waived if admitted)*	$200 copay
URGENT CARE	60% after deductible
AMBULANCE (Not covered as routine transportation)	No Copay
OUTPATIENT SURGERY	60% after deductible
INPATIENT HOSPITAL SERVICES	60% after deductible
SKILLED NURSING FACILITY *(in lieu of hospitalization for medically necessary covered benefits)*	60% after deductible 240 days and 35 physician visits per calendar year
MATERNITY	
First Ob/Gyn Visit	60% after deductible
Inpatient Hospital Services	60% after deductible

Sample

THIS DISCLOSURE FORM IS ONLY A SUMMARY.
THE PLAN'S EVIDENCE OF COVERAGE SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

PLAN FEATURES	Out-of-Network (Non-Referred Coverage)
HOME HEALTH CARE	60% after deductible
PRIVATE DUTY or SPECIAL DUTY NURSING	60% after deductible (Same limitations as In-Network)
HOSPICE - INPATIENT	60% after deductible $10,000 lifetime maximum on Combined Inpatient and Outpatient
HOSPICE - OUTPATIENT	60% after deductible $10,000 lifetime maximum on Combined Inpatient and Outpatient
FAMILY PLANNING/REPRODUCTIVE SERVICES **Sterilization Procedures**	60% after deductible. Certain services are covered. Same limitations as In-Network.
MENTAL HEALTH	
Inpatient *(30 days per calendar year)*	60% after deductible
Outpatient *(20 visits per calendar year)*	50% after deductible
SUBSTANCE ABUSE DETOXIFICATION	
Inpatient Detoxification	60% after deductible
Outpatient Detoxification	60% after deductible
SUBSTANCE ABUSE REHABILITATION	
Inpatient *(30 days per calendar year)*	Not Covered
Outpatient *(20 visits per calendar year)*	Not Covered
DIABETIC SUPPLIES	60% after deductible
CHIROPRACTIC CARE	60% after deductible
DURABLE MEDICAL EQUIPMENT	60% after deductible Must pre-certify if over $1,500
PRESCRIPTION DRUG RIDER ***No Mandatory Generics*** 31 - 90 day supply included for Mail Order Delivery (MOD) - 2 times the 30 day supply. Open formulary - Covers drugs on the formulary exclusion list.	No coverage
ADDITIONAL PHARMACY OPTIONS	
Contraceptive Option	Not Covered
Performance Option	Not Covered
DENTAL	Not Covered
VISION CORRECTIVE LENSES/CONTACTS ALLOWANCE	Not Covered
ADVANCED REPRODUCTIVE TECHNOLOGY Available In-network only to groups with 500+ employees	Not Covered
MEDICAL SPENDING FUND Individual/Family Limits	Not Available

Sample

What's Not Covered
Exclusions and Limitations

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

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Blood and blood byproducts, except as administered on an inpatient or emergency care basis.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval.
- Durable Medical Equipment.
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Hearing aids.
- Home births.
- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectible drugs including injectible infertility drugs.
- Infertility services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services unless specifically listed as covered in your plan documents.
- Long-term rehabilitation therapy.
- Nonmedically necessary services or supplies.
- Orthotics except when applied to Diabetes-related care, supplies and treatment.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies, counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Treatment of behavioral disorders.

Quality Point-of-Service benefits are provided and or administered by Aetna Health Inc. and/or Corporate Health Insurance Company.

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Sample

Limitations

In the event there are two or more alternative Medical Services which in the sole judgment of CHI are equivalent in quality of care, CHI reserves the right to provide coverage only for the least costly Medical Service, as determined by CHI, provided that CHI approves coverage for the Medical Service or treatment in advance.

QPOS and USAccess referred benefits may be provided or administered by: Aetna Health Inc. Inc., and/or Corporate Health Insurance Company.

This material is intended for distribution only to employers and other plan sponsors.

Specific products may not be available in both self-funded and insured forms.

For any service or supply that is subject to a maximum limitation, such maximums will be reduced by any services or supplies which are covered as referred or non-referred benefits under a point-of-service program. Benefit limits offset and do not duplicate each other.

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THE PLAN'S EVIDENCE OF COVERAGE SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

Aetna Health Inc.
Arizona
Aetna Open Access Plan

Referrals are not required for a member to access in-network, covered services. Preauthorization for certain services is required. The Primary Care Physician Office Visit (PCP) copay pertains only to a member's selected PCP; the applicable specialist copay applies to any other participating physician office visits.

PLAN FEATURES	In-Network
FINANCIAL	
Maximum Out of Pocket	$1,500-Individual/$3000-Family
Plan Deductible: Individual / Family Limit	$100-Individual/$300-Family
Coinsurance	N/A
Coinsurance Limit: Single / Family	N/A
Lifetime Maximum Benefit	N/A
PHARMACY DEDUCTIBLE Individual / Family Limit	N/A
PHYSICIAN (PCP) OFFICE VISITS	
Office Hours	$25 copay
After Hours / Home Visits	$30 copay
SPECIALTY CARE	
Office Visits	$25 copay
Diagnostic Outpatient Lab / X-rays / Testing *(At facility)*	$25 copay
Diagnostic Outpatient Lab / X-rays / Testing *(At specialist)*	Included in Specialist Office Visit copay
Outpatient Therapy *(Physical, occupational or speech)*	$25 copay; Treatment over a 60-day consecutive period per incident of illness or injury beginning with the first day of treatment
Outpatient Dialysis/Chemotherapy	$25 copay
Allergy Testing/Treatment	$25 copay for testing. $25 copay for allergy injection in PCP office. No serum copay.
PREVENTIVE CARE	
Routine Physicals	$25 copay
Routine Child and Well Baby Care; Including immunizations	$25 copay
Routine GYN Care	$25 copay. One routine GYN visit and pap smear/365 days. Direct access to participating providers
Routine Mammography	$25 copay; One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over.
Routine Eye Exam	$25 copay. Direct access to participating providers; Frequency and Age Schedules may apply
Hearing Exam	$25 copay. Routine hearing screenings.
Hearing Aids	Not covered
EMERGENCY ROOM	$200 copay
URGENT CARE	$100 copay
AMBULANCE *(Not covered as routine transportation)*	No Copay
OUTPATIENT SURGERY	$50 copay

Sample

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THE PLAN'S EVIDENCE OF COVERAGE SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

PLAN FEATURES	In-Network
INPATIENT HOSPITAL SERVICES	$100 copay
SKILLED NURSING FACILITY *(in lieu of hospitalization for medically necessary covered benefits)*	$100 copay
MATERNITY	
First Ob/Gyn Visit	$25 copay for initial visit only.
Inpatient Hospital Services	$100 copay
HOME HEALTH CARE	No Copay
PRIVATE DUTY or SPECIAL DUTY NURSING	Not covered unless pre-authorized by HMO; no copay when covered
HOSPICE - INPATIENT	$100 copay
HOSPICE - OUTPATIENT	No copay
FAMILY PLANNING/REPRODUCTIVE SERVICES Sterilization Procedures	Covered with applicable specialist, outpatient surgery or inpatient hospital copay. Reversal of voluntary sterilization including related follow-up care and treatment of complications of such procedures is not covered.
MENTAL HEALTH	
Inpatient *(30 days per calendar year)*	$100 copay
Outpatient *(20 visits per calendar year)*	$25 copay
SUBSTANCE ABUSE DETOXIFICATION	
Inpatient Detoxification	$100 copay
Outpatient Detoxification	$25 copay
SUBSTANCE ABUSE REHABILITATION	
Inpatient *(30 days per calendar year)*	$100 copay
Outpatient *(20 visits per calendar year)*	$25 copay
DIABETIC SUPPLIES	RX copay if RX rider purchased; otherwise PCP copay applies
CHIROPRACTIC CARE	$25 copay; Limited to 20 visits per calendar year No PCP referral needed. Requires direct access to medically necessary chiropractic services
DURABLE MEDICAL EQUIPMENT	No copay
PRESCRIPTION DRUG RIDER ***No Mandatory Generics***	$10 copay generic formulary; $30 copay brand formulary; $60 copay generic and brand non-formulary; up to 30 day supply.

31 - 90 day supply included for Mail Order Delivery (MOD) - 2 times the 30 day supply.
Open formulary - Covers drugs on the formulary exclusion list.

ADDITIONAL PHARMACY OPTIONS	
Contraceptive Option	Included in Prescription Drug Option
Performance Option	Included in Prescription Drug Option
DENTAL	Not Covered
VISION CORRECTIVE LENSES/CONTACTS ALLOWANCE	Not Covered
ADVANCED REPRODUCTIVE TECHNOLOGY Available In-network only to groups with 500+ employees	Not Covered
MEDICAL SPENDING FUND Individual/Family Limits	Not Available

Sample

**What's Not Covered
Exclusions and Limitations**

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

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Blood and blood byproducts, except as administered on an inpatient or emergency care basis.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval.
- Durable Medical Equipment.
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Hearing aids.
- Home births.
- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectible drugs including injectible infertility drugs.
- Infertility services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services unless specifically listed as covered in your plan documents.
- Long-term rehabilitation therapy.
- Nonmedically necessary services or supplies.
- Orthotics except when applied to Diabetes-related care, supplies and treatment.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies, counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Treatment of behavioral disorders.

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Sample

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THE PLAN'S EVIDENCE OF COVERAGE SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

Aetna Health Inc.
Arizona
Aetna Choice POS Plan

Referrals are not required for a member to access in-network, covered services. Preauthorization for certain services is required. The Primary Care Physician Office Visit (PCP) copay pertains only to a member's selected PCP; the applicable specialist copay applies to any other participating physician office visits.

PLAN FEATURES	In-Network
FINANCIAL	
Maximum Out of Pocket	$1,500-Individual/$3000-Family
Plan Deductible: Individual / Family Limit	N/A
Coinsurance	N/A
Coinsurance Limit: Single / Family	N/A
Lifetime Maximum Benefit	N/A
PHARMACY DEDUCTIBLE Individual / Family Limit	N/A
PHYSICIAN (PCP) OFFICE VISITS	
Office Hours	$25 copay
After Hours / Home Visits	$30 copay
SPECIALTY CARE	
Office Visits	$25 copay
Diagnostic Outpatient Lab / X-rays / Testing *(At facility)*	$25 copay
Diagnostic Outpatient Lab / X-rays / Testing *(At specialist)*	Included in Specialist Office Visit copay
Outpatient Therapy *(Physical, occupational or speech)*	$25 copay; Treatment over a 60-day consecutive period per incident of illness or injury beginning with the first day of treatment
Outpatient Dialysis/Chemotherapy	$25 copay
Allergy Testing/Treatment	$25 copay for testing. $25 copay for allergy injection in PCP office. $0 serum copay.
PREVENTIVE CARE	
Routine Physicals	$25 copay
Routine Child and Well Baby Care; Including immunizations	$25 copay
Routine GYN Care	$25 copay. One routine GYN visit and pap smear/365 days. Direct access to participating providers
Routine Mammography	$25 copay; One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over.
Routine Eye Exam	$25 copay. Direct access to participating providers; Frequency and Age Schedules may apply
Hearing Exam	$25 copay. Routine hearing screenings.
Hearing Aids	Not covered
EMERGENCY ROOM	$200 copay
URGENT CARE	$200 copay
AMBULANCE *(Not covered as routine transportation)*	No Copay

Sample

THIS DISCLOSURE FORM IS ONLY A SUMMARY.
THE PLAN'S EVIDENCE OF COVERAGE SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

PLAN FEATURES	In-Network
OUTPATIENT SURGERY	$50 copay
INPATIENT HOSPITAL SERVICES	$100 copay
SKILLED NURSING FACILITY *(in lieu of hospitalization for medically necessary covered benefits)*	$100 copay
MATERNITY	
First Ob/Gyn Visit	$25 copay for initial visit only.
Inpatient Hospital Services	$100 copay
HOME HEALTH CARE	No Copay
PRIVATE DUTY or SPECIAL DUTY NURSING	Not covered unless pre-authorized by HMO; no copay when covered
HOSPICE - INPATIENT	$100 copay
HOSPICE - OUTPATIENT	No copay
FAMILY PLANNING/REPRODUCTIVE SERVICES Sterilization Procedures	Covered with applicable specialist, outpatient surgery or inpatient hospital copay. Reversal of voluntary sterilization including related follow-up care and treatment of complications of such procedures is not covered.
MENTAL HEALTH	
Inpatient *(30 days per calendar year)*	$100 copay
Outpatient *(20 visits per calendar year)*	$25 copay
SUBSTANCE ABUSE DETOXIFICATION	
Inpatient Detoxification	$100 copay
Outpatient Detoxification	$25 copay
SUBSTANCE ABUSE REHABILITATION	
Inpatient *(30 days per calendar year)*	$100 copay
Outpatient *(20 visits per calendar year)*	$25 copay
DIABETIC SUPPLIES	RX copay if RX rider purchased; otherwise PCP copay applies
CHIROPRACTIC CARE	$25 copay; Limited to 20 visits per calendar year No PCP referral needed. Requires direct access to medically necessary chiropractic services
DURABLE MEDICAL EQUIPMENT	No copay
PRESCRIPTION DRUG RIDER ***No Mandatory Generics***	$10 copay generic formulary; $30 copay brand formulary; $60 copay generic and brand non-formulary; up to 30 day supply.

31 - 90 day supply included for Mail Order Delivery (MOD) - 2 times the 30 day supply.
Open formulary - Covers drugs on the formulary exclusion list.

ADDITIONAL PHARMACY OPTIONS	
Contraceptive Option	Included in Prescription Drug Option
Performance Option	Included in Prescription Drug Option
DENTAL	Not Covered
VISION CORRECTIVE LENSES/CONTACTS ALLOWANCE	Not Covered
ADVANCED REPRODUCTIVE TECHNOLOGY Available In-network only to groups with 500+ employees	Not Covered
MEDICAL SPENDING FUND Individual/Family Limits	Not Available

Sample

THIS DISCLOSURE FORM IS ONLY A SUMMARY.
THE PLAN'S EVIDENCE OF COVERAGE SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

What's Not Covered
Exclusions and Limitations

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

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Blood and blood byproducts, except as administered on an inpatient or emergency care basis.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval.
- Durable Medical Equipment.
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Hearing aids.
- Home births.
- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectible drugs including injectible infertility drugs.
- Infertility services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services unless specifically listed as covered in your plan documents.
- Long-term rehabilitation therapy.
- Nonmedically necessary services or supplies.
- Orthotics except when applied to Diabetes-related care, supplies and treatment.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies, counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Treatment of behavioral disorders.

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Sample

THIS DISCLOSURE FORM IS ONLY A SUMMARY.
THE PLAN'S EVIDENCE OF COVERAGE SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

Aetna Health Inc.
Administered by Corporate Health Insurance Company
Arizona
Aetna Choice POS Out Of Network Plan

PLAN FEATURES	Out-of-Network*
FINANCIAL	
Plan Deductible: Individual / Family Limit	$100-Individual/$300-Family
Coinsurance Benefit paid by plan	60%
Coinsurance Limit: Single / Family	$5,000-Individual/$15,000-Family
Lifetime Maximum Benefit	$1,000,000
PRIMARY CARE PHYSICIAN VISITS (for illness and injury only)	
Office Hours	60% after deductible
After Hours / Home Visits	60% after deductible
SPECIALTY CARE	
Office Visits	60% after deductible
Diagnostic Outpatient Lab / X-rays / Testing *(At facility)*	60% after deductible
Diagnostic Outpatient Lab / X-rays / Testing *(At specialist)*	60% after deductible
Outpatient Therapy *(Physical, occupational or speech)*	60% after deductible. Treatment over a 60-day consecutive period per incident of illness or injury beginning with the first day of treatment.
Outpatient Dialysis/Chemotherapy	60% after deductible
Allergy Testing/Treatment	60% after deductible
PREVENTIVE CARE	
Routine Physicals	Not covered unless optional preventive care rider is purchased.
Routine Child and Well Baby Care; Including immunizations	Not covered unless optional preventive care rider is purchased.
Routine GYN Care	Not covered unless optional preventive care rider is purchased.
Routine Mammography	60% after deductible; One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over.
Routine Eye Exam	Not covered
Hearing Exam	60% after deductible for illness or injury.
Hearing Aids	Not covered
EMERGENCY CARE	(Same as In-Network Coverage)
URGENT CARE FACILITY	60% after deductible
AMBULANCE *(Not covered as routine transportation)*	(Same as In-Network Coverage)
OUTPATIENT SURGERY	60% after deductible
HOSPITALIZATION	60% after deductible
SKILLED NURSING FACILITY *(in lieu of hospitalization for medically necessary covered benefits)*	60% after deductible 240 days and 35 physician visits per calendar year
MATERNITY	
First Ob/Gyn Visit	60% after deductible
Inpatient Hospital Services	60% after deductible
HOME HEALTH CARE	60% after deductible

Sample

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PRIVATE DUTY or SPECIAL DUTY NURSING	60% after deductible (Same limitations as In-Network)
HOSPICE - INPATIENT	60% after deductible $10,000 lifetime maximum on Combined Inpatient and Outpatient
HOSPICE - OUTPATIENT	60% after deductible $10,000 lifetime maximum on Combined Inpatient and Outpatient
FAMILY PLANNING/REPRODUCTIVE SERVICES **Sterilization Procedures**	60% after deductible. Certain services are covered. Same limitations as In-Network.
MENTAL HEALTH	
Inpatient *(30 days per calendar year)*	60% after deductible
Outpatient *(20 visits per calendar year)*	50% after deductible
SUBSTANCE ABUSE DETOXIFICATION	
Inpatient Detoxification	60% after deductible
Outpatient Detoxification	60% after deductible
SUBSTANCE ABUSE REHABILITATION	
Inpatient *(30 days per calendar year)*	Not Covered
Outpatient *(20 visits per calendar year)*	Not Covered
DIABETIC SUPPLIES	60% after deductible
CHIROPRACTIC CARE	60% after deductible
DURABLE MEDICAL EQUIPMENT	60% after deductible Must pre-certify if over $1,500
OUT-OF-NETWORK ALL PREVENTIVE CARE RIDER ***(excluding mandated benefits)***	No coverage

Sample

**What's Not Covered
Exclusions and Limitations**

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

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Blood and blood byproducts, except as administered on an inpatient or emergency care basis.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval.
- Durable Medical Equipment.
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Hearing aids.
- Home births.
- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectible drugs including injectible infertility drugs.
- Infertility services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services unless specifically listed as covered in your plan documents.
- Long-term rehabilitation therapy.
- Nonmedically necessary services or supplies.

- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies, counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
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Limitations

In the event there are two or more alternative Medical Services which in the sole judgment of CHI are equivalent in quality of care, CHI reserves the right to provide coverage only for the least costly Medical Service, as determined by CHI, provided that CHI approves coverage for the Medical Service or treatment in advance.

QPOS and USAccess referred benefits may be provided or administered by: Aetna Health Inc. and/or Corporate Health Insurance Company.

This material is intended for distribution only to employers and other plan sponsors.

Specific products may not be available in both self-funded and insured forms.

For any service or supply that is subject to a maximum limitation, such maximums will be reduced by any services or supplies which are covered as referred or non-referred benefits under a point-of-service program. Benefit limits offset and do not duplicate each other.

Sample

Health Insurance Portability and Accountability Act Member Notice*

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

Pre-existing Conditions Exclusion Provision (only for plans containing such provision)

This is to advise you that a pre-existing conditions exclusion period may apply to you, if a pre-existing conditions exclusion provision is included in the Group Plan that you are or become covered under. If your plan contains a pre-existing conditions exclusion, such exclusion may be waived for you if you have prior Creditable Coverage.

Creditable Coverage

Creditable coverage includes coverage under a group health plan (including a governmental or church plan), health insurance coverage (either group or individual insurance), Medicare, Medicaid, military-sponsored health care (TRICARE), a program of the Indian Health Service, a State health benefit risk pool, the FEHBP, a public health plan as defined in the regulations, and any health benefit plan under section 5(c) of the Peace Corps Act. Not included as Creditable Coverage is any coverage that is exempt from the law (e.g., dental only coverage or dental coverage that is provided in a separate plan or even if in the same plan as medical, is separately elected and results in additional premium).

If you had **prior creditable coverage** within the 90 days immediately before the date you enrolled under this plan, then the pre-existing conditions exclusion in your plan, if any, will be **waived**. The determination of the 90-day period will not include any waiting period that may be imposed by your employer before you are eligible for coverage.

If you had **no prior creditable coverage** within the 90 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 90-day gap from the date your prior coverage terminated to your enrollment date), we will **apply** your plan's pre-existing conditions exclusion (to a maximum period of 12 months).

Please Note: If a state law mandates a gap period greater than 90 days, that longer gap period will be used to determine creditable coverage.

If you have any questions regarding the determination of whether or not a pre-existing conditions exclusion applies to you, please call the Member Services telephone number on your ID card.

Providing Proof of Creditable Coverage

Generally, you will have received a **Certification Of Prior Group Health Plan Coverage** from your prior medical plan as proof of your prior coverage. You should retain that Certification until you submit a medical claim. When a claim for treatment of a potential pre-existing condition is received, the claim office will request from you that **Certification Of Prior Group Health Plan Coverage**, which will be used to determine if you have Creditable Coverage at that time.

You may request a Certification Of Prior Group Health Plan Coverage from your prior carrier(s) with whom you had coverage within the past two years. Our Service Center can assist you with this and can provide you with the type of information that you will need to request from your prior carrier.

The Service Center may also request information from you regarding any pre-existing condition for which you may have been treated in the past, and other information that will allow them to determine if you have creditable coverage.

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Special Enrollment Periods

Due to Loss of Coverage

If you are eligible for coverage under your employer's medical plan but do/did not enroll in that medical plan because you had other medical coverage, and you lose that other medical coverage, you will be allowed to enroll in the current medical plan during special enrollment periods after your initial eligibility period, if certain conditions are met. These Special Enrollment Rules apply to employees and/or dependents who are eligible, but not enrolled for coverage, under the terms of the plan.

An employee or dependent is eligible to enroll during a special enrollment period if each of the following conditions are met:

- When you declined enrollment for you or your dependent, you stated in writing that coverage under another group health plan or other health insurance was the reason for declining enrollment, if the employer required such written notice and you were given notice of the requirement and the consequences of not providing the statement; and
- When you declined enrollment for you or your dependent, you or your dependent had COBRA continuation coverage under another plan and that COBRA continuation coverage has since been exhausted,

  or

  If the other coverage that applied to you or your dependent when enrollment was declined was not under a COBRA continuation provision, either the other coverage has been terminated as a result of the loss of eligibility or employer contributions toward that coverage have been terminated. Loss of eligibility includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, or reduction in hours of employment.

For Certain Dependent Beneficiaries

If your Group Health Plan offers dependent coverage, it is required to offer a dependent special enrollment period for persons becoming a dependent through marriage, birth, or adoption or placement for adoption. The dependent special enrollment period will last for 31 days from the date of the marriage, birth, adoption or placement for adoption. The dependent may be enrolled during that time as a dependent of the employee. If the employee is eligible for enrollment, but not enrolled, the employee may also enroll at this time. In the case of the birth or adoption of a child, the spouse of the individual also may be enrolled as a dependent of the employee if the spouse is otherwise eligible for coverage but not already enrolled. If an employee seeks to enroll a dependent during the special enrollment period, the coverage would become effective as of the date of birth, of adoption or placement for adoption, or marriage.

Special Enrollment Rules

To qualify for the special enrollment, individuals who meet the above requirements must submit a signed request for enrollment no later than 31 days after one of the events described above. The effective date of coverage for individuals who lost coverage will be the date of the qualifying event. If you seek to enroll a dependent during the special enrollment period, coverage for your dependent (and for you, if also enrolling) will become effective as of the date that the qualifying event occurred, (for marriage, as of the enrollment date) once the completed request for enrollment is received.

As of 7/1/2005 this addendum replaces the Health Insurance Portability and Accountability Act Member Notice that appears elsewhere in this disclosure. See your Benefit Summary for information regarding preexisting conditions exclusions.

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

Special Enrollment Rights

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

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

To request special enrollment or obtain more information, contact your benefits administrator.

Request for Certificate of Creditable Coverage

Members of insured plan sponsors and members of self insured plan sponsors who have contracted with us to provide Certificates of Prior Health Coverage have the option to request a certificate. This applies to terminated members, and it applies to members who are currently active but who would like a certificate to verify their status. Terminated members can request a certificate for up to 24 months following the date of their termination. Active member can request a certificate at any time. To request a Certificate of Prior Health Coverage, please contact Member Services at the telephone number on the back of your ID card.

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Notice to Members

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