

Important Disclosure Information*

Massachusetts

HMO, Aetna Open Access®, Aetna Choice® POS, USAccess®, and QPOS® Members

DISCLOSURE NOTICE

This disclosure notice is provided in accordance with the laws of the Commonwealth of Massachusetts. This disclosure notice is only a summary of certain provisions of the plan. The Aetna policy, agreement, or certificate of coverage should be consulted to determine governing contractual provisions. Members may contact Aetna at the telephone number shown on their I.D. Card.**

TERMINATION OF COVERAGE

A member's coverage may be cancelled, or its renewal refused, only in the following circumstances.

1. Failure by the member or other responsible party to make payments required under the contract;
2. Misrepresentation or fraud on the part of the member;
3. Commission of acts of physical or verbal abuse by the member which pose a threat to providers or other members of the Aetna and which are unrelated to the physical or mental condition of the member;
4. Relocation of the member outside the service area of Aetna;
5. Non-renewal or cancellation of the group contract through which the member receives coverage; or
6. Failure by the member to meet the eligibility requirements of the contract.

CLAIM PROCEDURES/COMPLAINTS AND APPEALS

CLAIM PROCEDURES

A claim occurs whenever a Member or the Member's authorized representative requests preauthorization 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 Aetna Member, most claims do not require forms to be submitted.

* State mandates do not apply to self-funded plans. If you are unsure if your plan is self-funded, please contact your benefits administrator.

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

www.aetna.com

01.28.302.1-MA (7/05)

However, if a Member receives a bill for Covered Benefits, the bill must be submitted promptly to Aetna for payment. Send the itemized bill for payment with the Member's identification number clearly marked to the address shown on the Member's ID card.

Aetna will make a decision on the Member's claim. For urgent care claims and preservice claims, the Aetna will send the Member written notification of the determination, whether adverse or not adverse.

Aetna shall make an initial Utilization Review determination regarding a proposed admission, procedure or service claim within two (2) working days of obtaining all necessary information. Necessary information shall include the results of any face-to-face clinical evaluation or second opinion that may be required. In the case of a determination to approve a Utilization Review admission, procedure or service, Aetna shall notify the Provider rendering the service by telephone within 24 hours, and shall provide written or electronic confirmation of the telephone notification to the Member and the Provider within two (2) working days thereafter.

Aetna shall make a concurrent Utilization Review determination within one (1) working day of obtaining all necessary information. In the case of a determination to approve a concurrent claim, Aetna shall notify the Provider rendering the service by telephone within one (1) working day, and shall provide written or electronic confirmation to the Member and the Provider within one (1) working day thereafter. The written or electronic notification shall include the number of extended days or the next review date, the new total number of days or services approved, and the date of admission or initiation of services.

For other types of claims, the Member may only receive notice if Aetna makes an adverse determination.

A Member may contact Member Services at the toll-free telephone number on their ID card to determine the status or outcome of Utilization Review decisions.



ADVERSE DETERMINATIONS

Adverse 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 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 the requested service or supply 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; or
- an Aetna limitation has been reached; or
- Eligibility. Aetna determines that the Subscriber or Subscriber's Covered Dependents are not eligible to be covered.

The written notice of an adverse determination shall include a substantive clinical justification that is consistent with generally accepted principals of professional medical practice and shall, at a minimum, also provide the following important information that will assist the Member in making an Appeal of the Adverse Determination, if the Member wishes to do so:

- (a) identify the specific information upon which the adverse determination was based;
- (b) discuss the Member's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria;
- (c) specify any alternative treatment options covered by Aetna, if any;
- (d) reference and include applicable clinical practice guidelines and review criteria; and
- (e) a clear, concise and complete description of the Aetna's formal internal Appeal process and the procedures for obtaining external review, including the procedure to request an expedited external review.

Written notices of an Adverse Determinations will be provided to the Member within the following time frames. Under certain circumstances, these time frames may be extended. Please see the Complaint and Appeals section of this Certificate for more information about Appeals.

UTILIZATION REVIEW

Aetna Timeframe for Notification of a Utilization Review Adverse Determination	
Type of Claim	Aetna Response Time from Receipt of Appeal 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.	Telephone the Provider within 24 hours. Send written or electronic confirmation of the telephone notification to the Member and the Provider within one working day thereafter
Proposed Admission, Procedure or Service. A claim for a benefit that requires preauthorization of the benefit in advance of obtaining medical care.	Telephone the Provider within 24 hours. Send written or electronic confirmation of the telephone notification to the Member and the Provider within one working day thereafter.
Concurrent Care Claim Extension. A request to extend a course of treatment previously preauthorized by Aetna.	Telephone the Provider within 24 hours. Send written or electronic confirmation of the telephone notification to the Member and the Provider within one working day thereafter. The service shall be continued without liability to the Member until the Member has been notified of the determination.
Concurrent Care Claim Reduction or Termination. Decision to reduce or terminate a course of treatment previously preauthorized by Aetna.	Telephone the Provider within 24 hours. Send written or electronic confirmation of the telephone notification to the Member and the Provider within one working day thereafter. The service shall be continued without liability to the Member until the Member has been notified of the determination.
Post-Service Claim. A claim for a benefit that is not a proposed admission, procedure or service claim.	Within 30 calendar days

Aetna shall give a Provider treating a Member an opportunity to seek reconsideration of a Utilization Review adverse determination from a clinical peer reviewer in any case involving an initial determination or a concurrent review determination. The reconsideration process shall occur within one (1) working day of the receipt of the request and shall be conducted between the Provider rendering the service and the clinical peer reviewer or a

clinical peer designated by the clinical peer reviewer if the reviewer cannot be available within one (1) working day. If the reconsideration process does not reverse the Utilization Review adverse determination, the Member, or the Provider on behalf of the Member, may pursue the Appeal Process. The reconsideration process shall not be a prerequisite to the Appeal Process or an expedited Appeal.

NON-UTILIZATION REVIEW

Aetna Timeframe for Notification of a Non-Utilization Review 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 pre-authorization 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 pre-authorized 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 pre-authorized by Aetna.	With enough advance notice to allow the Member to Appeal.
Post-Service Claim. A claim for a benefit that is not a pre-service claim.	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 the Aetna. The procedure the Member needs to follow will depend on the type of issue or problem the Member has.

- **Inquiry.** An Inquiry is any communication that has not been the subject of an adverse determination and that request redress or an action, omission or policy of Aetna.
- **Appeal.** An Appeal is a request to Aetna to reconsider a Complaint or an adverse determination. The Appeal procedure for a Complaint or an adverse determination has two levels.
- **Complaint.** A Complaint is any Inquiry that has not been explained or resolved to the Member's satisfaction within three (3) business days of the Inquiry or any matter concerning an adverse determination.

A. INQUIRIES

The Inquiry Process is a process prior to the Appeal process during which Aetna may attempt to answer questions and/or resolve concerns communicated on behalf of the Member to the Member's satisfaction within three business days. This process shall not be used for review of an adverse determination, which must be reviewed through the Appeal process.

Aetna will address any Inquiry as expeditiously as possible, and provide a call back within 24 hours. A Member whose Inquiry has not been explained or resolved to the Member's satisfaction within three (3) business days of the Inquiry, has the right to have the Inquiry processed as a Complaint at his/her option, including reduction of an oral Inquiry to writing by Aetna, written acknowledgement and written resolution of the Complaint.

Aetna maintains records of each Inquiry communicated by a Member or on their behalf and each response thereto, for a minimum period of two (2) years. These records are subject to inspection by the Commissioner of Insurance and the Department of Public Health.

B. COMPLAINTS

If an Inquiry is not resolved in three business days or 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.

C. APPEALS

The Member will receive written notice about the Complaint or Adverse Determination from the 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.

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. All the rights of the Member also extend to the Member's authorized representative, which includes a Member's guardian, conservator, holder of a power of attorney, health care agent designated pursuant to the law, family member, or another person authorized by the Member in writing or by law with respect to a specific Appeal or external review, provided that if the Member is unable to designate a representative, where such designation would otherwise be required, a conservator, holder of a power of attorney, or family member in that order of priority may be the Member's representative or appoint another responsible party to serve as the Member's authorized representative. If the authorized representative is a health care provider, the Member must specify a named individual who will act on behalf of the authorized representative and a telephone number for that individual.

Requests for an Appeal must be made in by telephone, in person, by mail, or by electronic means within 180 calendar days from the date of the notice. Oral Appeals made by the Member, or the authorized representative, shall be reduced to writing by Aetna and a copy thereof forwarded to the Member by Aetna within 48 hours of receipt, except where this time limit is waived or extended by mutual written agreement of the Member of the Member's authorized representative and Aetna. A written acknowledgement of the receipt of an Appeal shall be sent to the Member or the Member's authorized representative, if any, within 15 business days of said receipt, except where an oral Appeal has been reduced to writing by Aetna or this time period is waived or extended by mutual written agreement of the Member or the Member's authorized representative and Aetna.

A Member may contact Member Services at the toll-free telephone number on their ID card for assistance in resolving Appeals. A Member may also contact the Office of Patient Protection at its toll-free telephone number 1-800-436-7757, facsimile 1-617-624-5046 or via the internet site at www.state.ma.us/dph/opp.

Aetna provides for two levels of Appeal plus an option to seek External Review or Arbitration. The described two-level Appeal process will be completed within 30 business days, regardless of the number of levels in the process. When an Appeal requires the review of medical records, the 30 business day period will not begin to run until the Member, or the Member's authorized representative, submits a signed authorization for release of medical records and treatment information. In the event the signed authorization is not provided by the Member, or the Member's authorized representative, if any, within 30 business days of the receipt of the Appeal, Aetna may, in its discretion, issue a resolution of the Appeal without review of some or all of the medical records.

In at least one level of review of an Appeal, the Appeal shall be reviewed with the participation of an individual who is an actively practicing health care professional in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment that is the subject of the Appeal. The Member must complete the two levels of Aetna's review before bringing a lawsuit against Aetna.

Any second level of Appeal is strictly voluntary and not a prerequisite to filing an external appeal to the Office of Patient Protection. 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.

The following chart summarizes some information about how the Appeals are handled for different types of claims.

<p align="center">Aetna Timeframe for Responding to an Appeal</p> <p align="center">Please refer to Section C. for information regarding certain types of Claims that may be eligible for an expedited Appeal Process.</p>		
Type of Claim	Level One Appeal Aetna's Response Time Level One Appeal from Receipt of Appeal	Level Two Appeal Aetna's Response Time Level Two Appeal 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 to regain maximum function; or subject the Member to severe pain that cannot be adequately managed without the requested care or treatment.	<p>Within 36 hours</p> <p>Review provided by Aetna's personnel not involved in making the Complaint or adverse determination.</p>	<p>Within 36 hours</p> <p>Review provided by Aetna's Appeals Committee.</p>
Pre-Service Claim. A claim for a benefit that requires approval of the benefit in advance of obtaining medical care.	<p>Within 15 calendar days</p> <p>Review provided by Aetna's personnel not involved in making the Complaint or Adverse B Determination.</p>	<p>Within 15 calendar days</p> <p>Review provided by Aetna's Appeals Committee.</p>
Concurrent Care Claim Extension. A request to extend or a decision to reduce a previously approved course of treatment.	<p>Treated like an urgent care claim or a pre-service claim depending on the circumstances</p>	<p>Treated like an urgent care claim or a pre-service claim depending on the circumstances</p>
Post-Service Claim. Any claim for a benefit that is not a pre-service claim.	<p>Within 30 business days</p> <p>Level I Review provided by Aetna personnel not involved in making the Complaint or adverse determination.</p> <p>Level II Review provided by Aetna's Appeals Committee.</p>	

The time limits stated above may be waived or extended by mutual written agreement of the Member or the Member's, authorized representative, and Aetna. Any such agreement shall state the additional time limits, which shall

not exceed 30 business days from the date of the agreement. If additional information is required and the Member does not agree to an extension, Aetna shall make a decision based on the information available.

If Aetna fails to reduce an oral Appeal to writing and forward a copy to the Member within 48 hours, fails to provide written acknowledgment of the receipt of an Appeal to the Member with 15 business days or fails to complete the two-level Appeal process within 30 business days, an Appeal shall be deemed resolved in favor of the Member. Time limits include any extensions made by mutual written agreement of the Member, or the Member's authorized representative, if any, and Aetna.

A written notice stating the results of the Appeal of the Adverse Determination shall include a substantive clinical justification that is consistent with generally accepted principals of professional medical practice that shall at a minimum:

- (a) identify the specific information upon which the Complaint or adverse determination was based;
- (b) discuss the Member's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria;
- (c) specify alternative treatment options covered by Aetna, if any;
- (d) reference and include applicable clinical practice guidelines and review criteria; and
- (e) notify the Member of the Member's authorized representative of the procedures for requesting external review, including the procedure to request an expedited external review.

If an Appeal is filed concerning the termination of ongoing coverage or treatment, the disputed coverage or treatment shall remain in effect at Aetna's expense through completion of the internal Appeal process, regardless of the original internal Appeal decision. Ongoing coverage or treatment include only that medical care that, at the time it was initiated, was authorized by Aetna and does not include medical care that was terminated pursuant to a specific time or episode-related exclusion from the Member's contact for benefits.

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

D. EXPEDITED APPEAL REVIEW PROCEDURES

1. In the event the Member is a Hospital inpatient, Member shall receive a written resolution of an expedited review, and the opportunity to request continuation of services, of the Appeal prior to Hospital discharge. If the expedited review results in an adverse benefit determination regarding the continuation of inpatient care, the written resolution must inform the Member or the Member's authorized representative of the opportunity to request an expedited external review.
2. In the event the Appeal is of an emergent or urgent nature where the Physician believes that denial of coverage for a Medically Necessary service would cause serious harm to the Member, an Aetna Medical Director shall review the matter as soon as possible or within 48 hours, and communicate a decision to the Member by telephone.
3. Provisions for the automatic reversal of decisions denying coverage for services or durable medical equipment, pending the outcome of the Appeal process, within 48 hours [or earlier for durable medical equipment at the option of a Physician responsible for treatment or proposed treatment of the covered patient] of receipt of certification by said Physician that, in the Physician's opinion:
 - a. the service or use of durable medical equipment at issue in an Appeal is Medically Necessary; a denial of coverage for such services or durable medical equipment would create a substantial risk of serious harm to the Member; and
 - b. such risk of serious harm is so immediate that the provision of such services or durable medical equipment should not await the outcome of the normal Appeal process.Provisions that require that, in the event a Physician exercises the option of automatic reversal earlier than 48 hours for durable medical equipment, the Physician must further certify as to the specific immediate and severe harm that will result to the Member absent action within the 48 hour time period.
4. In the event the Member has a terminal illness, an expedited review of the Appeal will be completed within 5 days from the receipt of the Appeal. If the expedited review process affirms the denial of coverage to a Member with a terminal illness, Aetna shall provide the Member, within five (5) business days of the decision:

- a. a statement setting forth the specific medical and scientific reasons for denying coverage;
- b. a description of alternative treatment, services or supplies covered by Aetna, if any; and
- c. the procedure for the Member to request a conference.

Aetna shall schedule such the conference within 10 days of receiving the request for a conference from a Member, at the conference the information provided to the Member pursuant to provisions (1) and (2) above shall be reviewed by the Member and a representative of Aetna who has authority to determine the disposition of the Appeal. Aetna shall permit attendance at the conference of the Member, a designee of the Member or both, or, if the Member is a minor or incompetent, the parent, guardian or conservator of the Member as appropriate. The conference shall be held within 5 business days if the treating Physician determines, after consultation with Aetna's Medical Director or designee, and based on standard medical practice, that the effectiveness of either the proposed treatment, services or supplies or any alternative treatment, services or supplies covered by Aetna, would be materially reduced if not provided at the earliest possible date.

E. EXTERNAL REVIEW PROCESS

A Member, who remains aggrieved by an adverse determination and has exhausted at least one level of Appeal from the formal Appeal process, may seek further review of the Appeal by a review panel established by the Office of Patient Protection. The request for an external review must be made within 45 days of receipt of Aetna's Appeal determination. For the purposes of this provision, an adverse determination is based upon a review of information provided by Aetna to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other health care services, for failure to meet the requirements for coverage based on Medical Necessity, appropriateness of health care setting and level of care, or effectiveness.

A Member or the Member's authorized representative, if any, may request to have his or her request for review processed as an expedited external review.

1. Any request for an expedited external review shall contain a certification, in writing, from a Physician, that delay in the providing or continuation of health care services that are the subject of a final adverse determination, would pose a serious and immediate threat to the health of the Member. Upon finding that a serious and immediate threat to the Member exists, the Office of Patient Protection shall qualify such request as eligible for an expedited external review.
2. A Member seeking a review shall pay a fee of \$25.00, to the Office of Patient Protection, which shall accompany the request for a review. The fee may be waived by said office if it determines that the payment of the fee would result in an extreme financial hardship to the Member.
3. The remained of the cost for an external review shall be borne by Aetna. Upon completion of the external review, the Office of Patient Protection shall bill Aetna the amount established pursuant to contract between the Department and the assigned external review agency minus the \$25.00 fee, which is the Member's responsibility.
4. In connection with any request for an external review, Aetna shall assure that the Member, and where applicable the Member's authorized representative, have access to any medical information and records relating to the insured, in the possession of Aetna or under Aetna's control.
5. Request for review submitted by the Member or the Member's authorized representative shall:
 - (a) be on a form prescribed by the Department;
 - (b) include the signature of the Member or the Member's authorized representative consenting to the release of medical information;
 - (c) include a copy of the written final adverse determination issued by Aetna; and
 - (d) include the required \$25 fee.

6. If the subject matter of the external review involves the termination of ongoing services, the Member may Appeal to the external review panel to seek the continuation of coverage for the terminated service during the period the review is pending. Any such request must be made before the end of the second business day following receipt of the final adverse determination. The review panel may order the continuation of coverage or treatment where it determines that substantial harm to the Member's health may result absent such continuation or for such other good cause as the review panel shall determine. Any such continuation of coverage shall be at the Aetna's expense regardless of the final external review determination.

7. The decision of the review panel shall be binding. The Office of Patient Protection, established by the Department of Public Health, is responsible for the administration and enforcement of certain Massachusetts Managed Care requirements. A Member may obtain the necessary forms to seek an external review by contacting the Office of Patient Protection at its toll-free telephone number 1-800-436-7757, facsimile 617-624-5046 or via the internet site at www.state.ma.us/dph/opp. A Member may also contact the Office of Patient Protection to obtain a report detailing, for the previous calendar year, the total number of:

- a) a list of sources of independently published information assessing the insured's satisfaction and evaluating the quality of health care services offered by Aetna.
- b) the percentage of Physicians who voluntarily and involuntarily terminated participation contracts with the carrier during the previous calendar year for which such data has been compiled and the three most common reasons for voluntary and involuntary Physician disenrollment;
- c) the percentage of premium revenue expended by the carrier for health care services provided to insureds for the most recent year for which information is available; and
- d) a report detailing, for the previous calendar year, the total number of:
 1. filed Appeals, Appeals that were approved internally, Appeals that were denied internally, and Appeals that were withdrawn before resolution; and
 2. external Appeals pursued after exhausting the internal Appeals process and the resolution of all such Appeals.

F. RECORD RETENTION

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

G. 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.

Note: The following section entitled "Dispute Resolution" has been added to the Certificate:

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, 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 non-participating 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. 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.

QUALITY ASSURANCE PROGRAMS

Aetna has developed a comprehensive Quality Improvement Program that places strict attention on quality measurement and improvement and is designed to identify and respond to the health care concerns of our members. Some of our quality-focused initiatives include:

1. Routine monitoring of quality of service and care, including:
 - The performance of medical chart review audits in the office setting,
 - Medical director review of member utilization patterns to determine prevalence of acute and chronic conditions, and the need for focused disease management programs,
 - Comprehensive utilization management and case management programs,
 - Review of survey results which assess member and provider satisfaction levels, and
 - Periodic analysis of provider availability and access.
2. Provider certification and recertification, as well as quality performance-based physician and facility contracting.
3. Adoption and use of practice guidelines, including preventive care recommendations.
4. Health promotion and wellness programs which seek to identify members who may be considered high-risk, and which offer incentives to members who participate and have predetermined goals in fitness, smoking-cessation, and weight loss programs.
5. The uses of an automated tracking system to monitor member complaints which help identify opportunities to improve service levels.
6. Programs to monitor and address potential underutilization, and denial or delay in providing needed services.
7. Measuring provider performance to improve the quality of care, assessing medical costs to improve the value of care, and delivering sophisticated and integrated data reporting products to customers.
8. The Quality Enhancement rewards primary care physicians for their scores on several measures intended to evaluate the quality of care and services the Primary Care Physicians provide to Members. Primary Care Physician 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 Primary Care Physician'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 primary care physician, 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.
9. Annual evaluation of the Quality Improvement Program, including voluntary review and accreditation by the National Committee for Quality Assurance (NCQA), an independent, not-for-profit organization dedicated to assessing and reporting on the quality of care and service delivered by managed care organizations.

EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES

Experimental or Investigational Procedures means services or supplies that are, as determined by Aetna, experimental. A drug, device, procedure or treatment will be determined to be experimental if:

1. there is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
2. required FDA approval has not been granted for marketing; or
3. a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or
4. the written protocol or protocol(s) used by the treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or
5. it is not of proven benefit for the specific diagnosis or treatment of a member's particular condition; or

- a) it is not generally recognized by the Medical Community as effective or appropriate for the specific diagnosis or treatment of a member's particular condition; or
- b) it is provided or performed in special settings for research purposes.

CONTINUITY OF CARE

- A. Aetna shall notify a member at least 30 days before the disenrollment of such member's primary care physician. A member may continue to be covered for health services, consistent with the terms of the certificate, by such primary care physician for at least 30 days after the physician is disenrolled, except for disenrollment for quality-related reasons or for fraud. A member may change their PCP at any time by calling the Member Services toll-free telephone number listed on their identification card or by written or electronic submission of the Aetna change form. A member 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.
- B. Coverage is provided for any female member who is in her second or third trimester of pregnancy and whose provider in connection with her pregnancy is involuntarily disenrolled, except for disenrollment for quality-related reasons or for fraud, to continue treatment with said provider, consistent with the terms of the certificate, for the period up to and including the member's first postpartum visit.
- C. Coverage is provided for any member who is terminally ill and whose provider in connection with said illness is involuntarily disenrolled, except for disenrollment for quality-related reasons or for fraud, to continue treatment with said provider, consistent with the terms of the certificate, until the member's death.
- D. Coverage is provide for covered services for up to 30 days from the effective date of coverage to a new member for services rendered by a non-participating provider if: (1) the member's employer only offers the member a choice of carriers in which said physician is not a participating provider, and (2) said physician is providing the member with an ongoing course of treatment or is the member's primary care physician. With respect to a member in her second or third trimester of pregnancy, this provision shall apply to services rendered through the first postpartum visit. With respect to a member with a terminal illness, this provision shall apply to services rendered until death.

- E. Aetna may condition coverage of continued treatment by a provider under subsections A. through D., inclusive, upon the providers' agreeing (1) to accept reimbursement from Aetna at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to the member in an amount that would exceed the cost sharing that could have been imposed if the provider had not been disenrolled; (2) to adhere to the quality assurance standards of Aetna and to provide Aetna with necessary medical information related to the care provided; and (3) to adhere to Aetna's policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing services pursuant to a treatment plan, if any, approved by Aetna. Nothing in this subsection shall be construed to require the coverage of benefits that would not have been covered if the provider involved remained a participating provider.

SPECIALIST PHYSICIAN

Covered Benefits include outpatient and inpatient services. If a member requires ongoing care from a specialist, the member may receive a standing referral to such specialist. If PCP in consultation with an Aetna Medical Director and an appropriate specialist determines that a standing referral is warranted, the PCP shall make the referral to a specialist. This standing referral shall be pursuant to a treatment plan approved by the Aetna Medical Director in consultation with the PCP, specialist and member. Coverage is provided for pediatric specialty care, including mental health care, by persons with recognized expertise in specialty pediatrics to members requiring such services.

DIRECT ACCESS SPECIALIST BENEFITS

The following services are covered without a referral when rendered by a participating provider.

1. Routine Gynecological Examination(s). Routine gynecological visit(s) and pap smear(s), as well as medically necessary evaluations and resultant health care services for acute or emergency gynecological conditions. The maximum number of visits is provided in the certificate.
2. Open Access to Gynecologists. Benefits are provided to female members for services performed by a participating gynecologist for diagnosis and treatment of gynecological problems and maternity care.

Aetna will not require higher copayments, coinsurance, deductibles or additional cost sharing arrangements for direct access services provided to a member in the absence of a referral from the Primary Care Physician.

PHYSICIAN PROFILING

Physician profiling information is available from the Massachusetts Board of Registration in Medicine for physicians licensed to practice in Massachusetts.

CLINICAL GUIDELINES AND UTILIZATION REVIEW CRITERIA

Aetna uses a wide range of commercially developed and nationally recognized guidelines and criteria, internally developed guidelines, reference tools, and published medical literature to assist in determining the appropriate level of coverage for services.

Local quality committees, composed of community practicing physicians and health plan staff review, update and adopt the review criteria at least annually and more frequently as necessary.

These criteria may include:

- The Milliman Care Guidelines™.
- InterQual® ISD criteria.
- Western Region Experience of HCIA's Length of Stay (LOS) Guidelines
- Aetna developed Clinical Policy Bulletins
- Level of Care Assessment Tool (LOCAT)
- American Society of Addictive Medicine Patient Management Patient Placement Guidelines (ASAM)
- Aetna Internal policies and procedures

INTERPRETER AND TRANSLATION SERVICES

A member may contact Member Services at the telephone number listed on their member identification card to receive information on interpreter and translation services related to administrative procedures. A TDD# is also available.

EMERGENCY CARE / URGENT CARE BENEFITS

A member has the option of calling the local pre-hospital emergency medical service system by dialing the emergency telephone access number 911, or its local equivalent, whenever the member is confronted with an emergency medical condition which in the judgment of a prudent layperson would require pre-hospital emergency services. A member shall not be discouraged from using the local pre-hospital emergency medical service system, the 911 telephone number, or the local equivalent.

Medical transportation is covered for an Emergency Medical Condition.

The member should notify their primary care physician as soon as possible after emergency or urgent care treatment. Notice given to Aetna, designee or primary care physician by the attending emergency care physician shall satisfy this requirement.

Plan of Benefits

Your plan of benefits will be determined by your plan sponsor. Covered services include most types of treatment provided by primary care physicians, specialists and hospitals. However, the health plan does exclude and/or include limits on coverage for some services, including but not limited to, cosmetic surgery and experimental procedures. In addition, in order to be covered, all services, including the location (type of facility), duration and costs of services, must be **medically necessary** as defined below and as determined by Aetna. The information that follows provides general information regarding Aetna health plans. For a complete description of the benefits available to you, including procedures, exclusions and limitations, refer to your specific plan documents, which may include the Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Group Insurance Policy and any applicable riders and amendments to your plan.

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.

Role of Primary Care Physicians ("PCPs")

For most HMO 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 nonemergency specialty or hospital care. Check your plan documents for details.

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.
- The member 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 their PCP prior to receiving the services. If the member does not get another referral for these services, the member may be responsible for payment.
- 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 60 days as long as the individual remains an eligible member of the plan.
- In plans without out-of-network benefits, coverage for services from nonparticipating providers requires prior authorization by Aetna in addition to a special nonparticipating referral from the PCP. When properly authorized, these services are fully covered, less the applicable cost-sharing.
- The referral 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.

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 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 nonemergency or nonurgent care without a referral, you must pay the bill yourself unless the service is specifically identified as a direct access benefit in your plan documents.

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.

Direct Access Ob/Gyn Program

This program allows female members to visit any participating obstetrician or gynecologist for a routine well woman exam, including a Pap smear, and for obstetric or gynecologic problems. Obstetricians and gynecologists may also refer a woman directly to other participating providers for covered obstetric or gynecologic services. All health plan preauthorization and coordination requirements continue to apply. If your Ob/Gyn is part of an Independent Practice Association (IPA), a Physician Medical Group (PMG), an Integrated Delivery System (IDS) or a similar organization, your care must be coordinated through the IPA, the PMG or similar organization and the organization may have different referral policies.

Health Care Provider Network

All hospitals may not be considered participating for all services. Your physician can contact Aetna to identify a participating facility for your specific needs. Certain PCPs are affiliated with integrated delivery systems, independent practice associations ("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.

Transplants and Other Complex Conditions

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

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 HMO 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 HMO 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.

Prescription Drugs

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

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

Covered nonformulary prescription drugs may be subject to higher copayments or coinsurance under some benefit plans. Some prescription drug benefit plans may exclude from coverage certain nonformulary drugs that are not listed on the preferred drug list. If it is medically necessary for 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. Check your plan documents for details.

In addition, certain drugs may require precertification or step-therapy before they will be covered under some prescription drug benefit plans. Step-therapy is a different form of precertification 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. In addition, some benefit plans include a mandatory generic drug cost-sharing requirement. In these plans, you may be required to pay the difference in cost between a covered brand-name drug and its generic equivalent in addition to your copayment if you obtain the brand-name drug. Nonprescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received and/or available upon enrollment) are not covered, and medical exceptions are not available for them.

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

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

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

BEHAVIORAL HEALTH NETWORK

In Massachusetts, Magellan Behavioral Health provides in network mental health benefits for Aetna and QPOS Members.

You may seek treatment from a participating behavioral health professional without obtaining a referral from your PCP. Contact Aetna’s Behavioral Health Contractor, Magellan Behavioral Health (MBH) to:

- find a participating mental health provider in your area
- obtain pre-certification for mental health and substance abuse services.

Please follow the guidelines below when seeking mental health or substance abuse services:

- Contact MBH first so they can pre-certify and arrange all routine and urgent behavioral health and substance abuse services.
- If you have an emergency, please seek care immediately. If you need to go to an emergency room for mental health or substance abuse crisis, please contact MBH as soon as possible for assistance in managing the admission and any referrals for additional behavioral health services that may be needed. Although a PCP referral is not needed for these types of emergency room services, your PCP should be notified.

For more information on how to obtain Mental Health and Substance Abuse Services please call 1-800-424-6108.

You can also receive information regarding the appropriate way to access the behavioral health care services that are covered under your specific plan by calling the Member Services’ toll-free number on your I.D. card. As with other coverage determinations, you may appeal behavioral health care coverage decisions in accordance with the provisions of your health plan, or applicable state law.

Note: Some employers may have selected a behavioral health contractor other than **MBH** to manage their behavioral health benefits. If you have any questions with regard to the name of the behavioral health contractor for your group, please contact Member Services at 1-888-982-3862. You may also contact your employer’s Human Resource Department.

How Aetna Compensates Your Health Care Provider

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

Participating providers in our network are compensated in various ways:

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

One of the purposes of managed care is to manage the cost of health care. Incentives in compensation arrangements with physicians and health care providers are one method by which Aetna attempts to achieve this goal.

In some regions, the Primary Care Physicians can receive additional compensation based upon performance on a variety of measures intended to evaluate the quality of care and services the Primary Care Physicians provide to Members. This additional compensation is based on the scores received on one or more of the following measures of the Primary Care Physician'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 primary care physician;
- 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.

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

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

Medically Necessary

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

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

"Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community.

In the absence of such credible scientific evidence, the [Plan/HMO/Company's] determinations of whether a service or supply meets "generally accepted standards of medical practice" shall be consistent with physician specialty society recommendations and otherwise shall be based on the views of physicians practicing in relevant clinical areas and any other relevant factors.

Clinical Policy Bulletins (“CPBs”)

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

Aetna’s CPBs do not constitute medical advice. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any CPB related to their coverage or condition with their treating provider.

While Aetna’s CPBs are developed to assist in administering plan benefits, they do not constitute a description of plan benefits. Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their providers will need to consult the member’s benefit plan to determine if there are any exclusions or other benefit limitations applicable to this service or supply. CPBs are regularly updated and are therefore subject to change. Aetna’s CPBs are available online at www.aetna.com.

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 member’s transition from the inpatient setting to the next level of care (discharge planning), or to register members for specialized programs like disease management, case management, or maternity management programs. 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. When a member is to obtain services requiring precertification from a participating provider, the provider is responsible to 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.

Utilization Review/Patient Management

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

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

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

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.

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.

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 reviews all appeals of inpatient concurrent review decisions for coverage 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.

Complaints, Appeals and External Review*

Filing a Complaint or Appeal

Aetna is committed to addressing members' coverage issues, complaints and problems. If you have a coverage issue or other problem, call Member Services at the toll free number on your ID card. You can also contact Member Services through the Internet at:

www.aetna.com. If Member Services is unable to resolve your issue to your satisfaction, it will be forwarded to the appropriate department for handling.

If you are dissatisfied with the outcome of your initial contact, you may file an appeal. If you are not satisfied after filing a formal appeal, you may request a second level appeal of the decision. Your appeal will be decided in accordance with the procedures applicable to your plan and applicable state law. Refer to your plan documents for further details regarding your plan's appeal procedure.

External Review

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

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

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

Certain states mandate external review of additional benefit or service issues; some may require a filing fee. In addition, certain states mandate the use of their own external review process for medical necessity and experimental/ investigational coverage decisions. These state mandates may not apply to self-funded plans. For further details regarding your plan's appeal process and the availability of an external review process, call the Member Services toll-free number on your ID card or visit our website **www.aetna.com** where you may obtain an external review request form. You also may call your state insurance or health department or consult their website for additional information regarding state mandated external review procedures.

Confidentiality and Privacy Notices

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), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third-party administrators, vendors, consultants, government authorities, and their respective agents.

These parties are required to keep personal information confidential as provided by applicable law. Participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request. Some of the ways in which personal information is used include: claims payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health; early detection; disease and case management; quality assessment and improvement activities; auditing and antifraud activities; performance measurement and outcomes assessment; health claims analysis and reporting; health services research; data and information systems

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

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 hard copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please write to Aetna's Legal Support Services Department at 151 Farmington Avenue, W121, Hartford, CT 06156. You can also visit our Internet site at www.aetna.com. You can link directly to the Notice of Privacy Practices by selecting the "Privacy Notices" link at the bottom of the page.

Health Insurance Portability and Accountability Act 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)

Providing Proof of Creditable Coverage

Generally, you will have received a **certification of prior health 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 health coverage**, which will be used to determine if you have creditable coverage at that time.

You may request a **certification of prior health 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. 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 pre-existing conditions exclusion, such exclusion may be waived for you if you have prior creditable coverage.

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 pre-existing conditions exclusion applies to you, please call the Member Services telephone number on your ID card.

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).

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

* While this member notice is believed to be accurate as of the publication date, it is subject to change. Please contact the Member Services Department, if you have any questions.

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.

*While this Member Notice is believed to be accurate as of the publication date, it is subject to change. Please contact the Member Services department if you have any questions.

Notes

Notice to Members

While this information is believed to be accurate as of the print date, it is subject to change.

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 arranges for the provision of health care services. However, Aetna itself is not a provider of health care services and therefore, cannot guarantee any results or outcomes. Consult the plan documents [Group Agreement, Group Insurance Certificate, Schedule of Benefits, Certificate of Coverage, 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 and by plan design. These plans contain exclusions and some benefits are subject to limitations or visit maximums.

With the exception of Aetna Rx Home Delivery®, all participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC. is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law. Certain primary care physicians 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 nonsystem or nongroup 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.

The NCQA Accreditation Seal is a recognized symbol of quality. NCQA recognition seals appear in the provider directory next to those providers who have been duly recognized. NCQA provider recognitions are subject to change.

For up-to-date information, please visit our DocFind® online provider directory at www.aetna.com or visit the NCQA's new top-level recognition listing at recognition.ncqa.org.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. In-network and out-of-network referred benefits are underwritten by Aetna Health Inc. Self-referred benefits are underwritten by Corporate Health Insurance Company. For self-funded accounts, benefits coverage offered by your employer, with administrative services only provided by Aetna Life Insurance Company.

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