

Important Disclosure Information*

Missouri

For HMO, USAccess®, and QPOS® Members.

THIS HMO MAY HAVE RESTRICTIONS REGARDING WHICH PHYSICIANS OR OTHER HEALTH CARE PROVIDERS AN HMO MEMBER MAY USE. PLEASE CONSULT YOUR MEMBER HANDBOOK OR THIS PROVIDER DIRECTORY FOR MORE DETAILS. IF YOU HAVE ANY ADDITIONAL QUESTIONS, PLEASE WRITE TO US AT THE ADDRESS BELOW OR CALL US TOLL FREE AT 1-888-982-3862.

Aetna Health Inc.
1350 Elbridge Payne Rd.
Suite 201
Chesterfield, MO 63017

The HMO provides coverage for certain services and supplies. For a complete description of the coverage provisions, health care benefits, benefit maximums, benefit limitations and exclusions, please refer to the Certificate of Coverage. This information shall also be made available to prospective enrollees upon request.

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. This information shall also be made available to prospective enrollees upon request.

* 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

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Member Financial Responsibility

Members are responsible for all co-insurance, copayments and deductibles applicable under their particular plan and may be responsible for premiums depending on the terms of their plan. Please refer to the plan documents for a more detailed description of these responsibilities and the provisions pertaining to annual limits on your financial responsibility and limits on payments for covered services, if applicable.

In addition, you may also be financially responsible for services that are:

- provided by a health care provider who is not a participating provider;
- provided by a provider without obtaining any required authorization;
- not covered under the health plan; or
- related to out-of-area expenses. (Out-of-area expenses are reimbursed by some health plans. Refer to your plan design overview to determine if your plan does.)

Participating Providers

To select a participating provider, you may use the on-line provider directory at www.aetna.com or contact Member Services at 1-888-831-2751.

Participating providers are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. The availability of any particular provider cannot be guaranteed for referred or in-network benefits, and provider network composition is subject to change.

Not every provider listed in the directory will be accepting new patients. Although Aetna has identified providers who were not accepting patients as known to Aetna at the time the provider directory was created, the status of a provider's practice may have changed. For the most current information, you may contact the provider or Member Services at the toll-free number listed on your ID card.



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 that include benefits for nonparticipating provider services (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 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.

Direct Access Ob/Gyn Program

This program allows female members to visit any participating obstetrician and/or gynecologist for a routine well woman exam, including a Pap smear, and for obstetric and/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.

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 the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe that immediate medical care is required, which may include, but shall not be limited to:

- (a) Placing the person’s health in significant jeopardy;
- (b) Serious impairment to a bodily function;

- (c) Serious dysfunction of any bodily organ or part;
- (d) Inadequately controlled pain; or
- (e) With respect to a pregnant woman who is having contractions:

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.

Emergency Determination

When enrollee receives Emergency Services that require immediate post evaluation or post stabilization services, Aetna shall provide authorization within 60 minutes of receiving request. If authorization decision is not made within 30 minutes, such services shall be deemed approved.

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

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

The types of behavioral health benefits available to you depends upon the terms of your health plan. If your health plan includes behavioral health services, you may be covered for treatment of mental health conditions and/or drug and alcohol abuse problems. Members can determine the type of behavioral health coverage available under the terms of their plan 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. For routine services, access covered behavioral health services available under your health plan by the following methods:

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

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. Aetna will not retroactively deny covered nonemergency treatment that had prior authorization (precertification) under Aetna's written policies unless:

1. The authorization was based on a material misrepresentation or omission about the treated person's health condition or the cause of the health condition;
2. The group health plan terminated before the health care services were rendered; or
3. The member's coverage under the group health plan terminated before the health care services were rendered

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.

Initial Determinations

For Initial Determinations, Aetna shall make the initial determination within 2 working days of obtaining all necessary information. If the service is certified, Aetna shall notify your provider by telephone within 24 hours. Written or electronic confirmation will be provided to you or your designated representative and your provider within 2 working days of telephone notice. If there is an adverse determination, Aetna shall notify your provider by telephone within 24 hours. Written/electronic confirmation will be provided within 1 working day of telephone notice.

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.

For concurrent review determinations, Aetna must make the determination within 1 working day of obtaining all necessary information. If service is certified, Aetna shall notify your provider by telephone within 1 working day. Written/electronic confirmation will be provided to you or your designated representative, and your provider within 1 working day of telephone notice. If there is an adverse determination, Aetna shall notify your provider by telephone within 24 hours. Written/electronic confirmation will be provided within 1 working day of telephone notice. Service shall be continued without liability to you until you have been notified.

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 review all appeals of inpatient concurrent review decisions for coverage of healthcare 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.

For retrospective review determinations, Aetna shall make the determination within 30 working days of obtaining all necessary information. Notice of the determination will be provided to you in writing within 10 days of the determination.

Aetna has written procedures to address failure of the provider, member, or designated representative of member, to provide the necessary information. For cases in which you or your provider will not release the necessary information, Aetna may deny the services.

Reconsideration

For initial and concurrent review of services, Aetna shall give your provider an opportunity to request, on your behalf, a reconsideration of an adverse determination by the individual making the determination. Reconsideration shall occur within 1 working day of receipt of the request and shall be conducted between the provider and reviewer, or a clinical peer designated by the reviewer if the reviewer is not available. If this reconsideration does not resolve the issue, the adverse determination may be appealed by you, your designated representative, or your provider on your behalf. Reconsideration is not a prerequisite to an appeal.

Complaints, Appeals and External Review*

Filing a Complaint, Grievance or Appeal

Grievance Review

You, your designated representative, or your provider acting on your behalf may submit a grievance. Aetna will prepare a written acknowledgment of the grievance. The notice shall:

- i. acknowledge the grievance within 5 working days of receipt of the grievance;
- ii. invite you to provide any additional information to assist Aetna in handling and deciding the grievance;
- iii. inform you of your right to have an uninvolved Aetna representative assist you in understanding the grievance process; and
- iv. inform you as to when a response should be forthcoming.

All grievances will be investigated within 20 working days of receipt. Within 5 working days after the investigation is completed, someone who was not involved in the circumstances giving rise to the grievance or its investigation will decide upon the appropriate resolution of the grievance and notify the enrollee in writing of the decision and the right to file an appeal for a second level review. Within 15 working days after the investigation is completed, Aetna will notify the person who submitted the grievance of the decision. A pre-service grievance of a plan required pre-authorization will be resolved in 15 calendar days of the receipt of the request. All other grievances will be resolved in 30 calendar days of receipt of the request.

Grievance Hearing (Second Level Review)

You are entitled to a second level review by a committee if Aetna upholds and adverse benefit determination at the first level of appeal. A pre-service grievance of a plan required pre-authorization will be resolved in 15 calendar days of the receipt of the request. All other grievances will be resolved in 30 calendar days of receipt of the request.

Expedited Grievance

In the event a complaint requires specific action, and you or Aetna believes serious medical consequences will arise in the near future, you may request and will receive expedited review of your grievance. A grievance of a decision involving urgent care including urgent concurrent care will be resolved within 36 hours (each level).

Missouri Department of Insurance

You may contact the Department of Insurance for assistance regarding any inquiry, grievance or grievance appeal at:

Missouri Department of Insurance
Office of the Director
301 West High Street, Room 530
Jefferson City, Missouri 65101
1-800-726-7390

Members covered under insured plans may obtain additional information from state regulatory agencies regarding member rights. The state regulatory agency website for Missouri is: www.insurance.state.mo.us

*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

External Review

If you are dissatisfied with the outcome of your appeal, you may request a review by the Department of Insurance (DOI). If the appeal remains unresolved after completion of the consumer complaint process, the DOI will refer the appeal to an Independent Review Organization (IRO). Within 20 days of receipt of all the information, the IRO shall submit to the DOI its opinion of the issued reviewed. After the DOI receives the IRO's opinion, the director shall make a decision which is binding upon the enrollee and the health carrier. An expedited process is available to address clinical urgency.

The process for the IRO review is defined by Missouri regulation and is described in your plan documents. This external review process does not apply certain self-funded plans. You may call the Member Services toll-free telephone number on your ID card, call the Missouri Insurance Department or consult their website for additional information regarding the state's external review procedures.

Self-funded plan members should check with their plan sponsors for any additional information regarding the availability of an external review by an IRO.

For further details regarding your plan's grievance and external review process, call the Member Services toll-free number on your ID card or visit our website at www.aetna.com where you may obtain an external review request form.

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 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.

Member Participation

Aetna maintains a Membership Advisory Committee, approved by the Missouri Department of Insurance, to encourage members to participate in matters of Aetna's Policy and Operation. For more information or to submit any suggestions or comments to the Committee, please write to:

Aetna Health Inc.
Member Advisory Committee
C/O Quality Manager
Suite 200
1350 Elbridge Payne Rd.
Chesterfield, MO 63017

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

* 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.

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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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.

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**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.**