

Important Disclosure Information*

Pennsylvania

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

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

Coverage Description

Benefits are provided for many of the services and supplies needed for care and treatment of sickness and injuries or to maintain good health. Not all services and supplies are covered, some are covered only to a limited extent and some require precertification and referrals.

Some of the services and supplies for which benefits are provided include:

- Primary care physician (PCP) visits.
- Periodic health evaluations, including: well child care and immunizations; routine physical examinations; and routine hearing and vision screening.
- Injections, including allergy desensitization injections.
- Casts and dressings.
- Diagnostic, laboratory, and x-ray services.
- Specialist physician visits, including outpatient and inpatient services.
- Direct access specialists visits for routine gynecological visits and for diagnosis and treatment of gynecological problems.
- Maternity care and related newborn care.
- Inpatient hospital and skilled nursing facility care.
- Nonexperimental transplants.
- Outpatient surgery.
- Substance abuse care (inpatient/outpatient services for detoxification).
- Mental health care, including coverage for serious mental illnesses.
- Emergency care/urgent care.
- Physical, occupational and speech therapy.

* 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.

- Home health and hospice care.
- Prosthetic appliances.
- Reconstructive breast surgery following mastectomy.

Services and supplies that are generally not covered include, but are not limited to:

- Cosmetic surgery, including breast reduction.
- Special duty nursing unless medically necessary and preauthorized by Aetna.
- Blood and blood byproducts.
- Dental care and dental x-rays.
- Experimental and investigational procedures.
- Immunization for travel or work.
- Hearing aids.
- Orthotics.
- Long-term rehabilitation therapy.
- Prescription drugs and over-the-counter medications and supplies.
- Services for the treatment of sexual dysfunction or inadequacies including, therapy, supplies, counseling or prescription drugs.
- Home births.
- Durable medical equipment.
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- Reversal of sterilization.
- Infertility services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services.
- Donor egg retrieval.
- Radial keratotomy or related procedures.

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- Treatment for behavioral disorders.
- Therapy or rehabilitation other than those listed as covered.
- Nonmedically necessary services and supplies.

To be medically necessary, the service or supply must:

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

In determining if a service or supply is medically necessary, Aetna patient management medical director or its physician designee will consider:

- Information provided on the member's health status.
- Reports in peer reviewed medical literature.
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data.
- Professional standards of safety and effectiveness, which are generally recognized in the United States for diagnosis, care or treatment.
- The opinion of health professionals in the generally recognized health specialty involved.
- The opinion of the attending physicians, which have credence but do not overrule contrary opinions.

- Any other relevant information brought to Aetna's attention.

The issuance of a prior written referral in accordance with the Aetna policies and procedures by the member's PCP, or other physician providing service at the direction of the PCP, shall constitute proof of medical necessity for the purposes of determining a member's potential liability.

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.
- Female members may visit any participating gynecologist for a routine well-woman exam, including a Pap smear, and for gynecological problems without a referral from their PCP. Gynecologists may also refer a woman directly to other participating providers for covered gynecologic services.
- 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 non-participating providers requires prior authorization by Aetna in addition to a special non-participating 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.

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.

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

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

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Precertification

Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the services requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the member's PCP is coordination care, the PCP will obtain the precertification. When the member self-refers to a nonparticipating provider, member must obtain precertification.

Note: The full cost of care rendered may be the member's financial responsibility, if:

- The member fails to obtain the required authorization or precertify for services provided by a non-participating provider, or
- The care rendered is not covered by your plan.

The member should refer to their plan documents for a complete list of medical services that require precertification or that are not covered by their plan.

Member Cost Sharing

If your plan is contributory, you will be advised by your plan sponsor of the amount of your contribution when you enroll.

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 plan documents.

If your plan has a maximum limit, your cost for covered benefits made by or on behalf of a member shall not exceed the maximum out-of-pocket limit, during the contract year. You may submit for a refund of your covered benefits costs that exceed the maximum out-of-pocket limit.

Non-English Speaking Members

Aetna Member Services has a Spanish-speaking hotline - 1-800-533-6615. Also available is a Multilingual hotline - 1-888-982-3862 (140 languages are available. You must ask for an interpreter).

Aetna Provider Directory includes an Index of Providers Speaking Additional Languages sorted alphabetically by language spoken.

Mailing Address and Telephone Number

If a member needs to contact Aetna to obtain approval or authorization of a health care service, the member can write to:

Aetna Health Inc.
980 Jolly Road
P.O. Box 1109
Blue Bell, PA 19422

or call the toll free Member Services number on the ID card. Members can also contact Member Services by visiting us at www.aetna.com.

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 integrated delivery systems, independent practice associations 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 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.

Complaints, Appeals and External Review*

Complaints Process

Our complaints process is designed to address member 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. If Member Services is unable to resolve your issue, complaint or problem to your satisfaction, you can request that your concern be forwarded to the regional grievance unit or you may write to:

Mid-Atlantic Regional Grievance Unit

980 Jolly Road
P.O. Box 935
Blue Bell, PA 19422

You have the right to designate a representative to file complaints and appeals on your behalf. You can also contact Member Services through the Internet at www.aetna.com or at the toll-free number on your ID card for more information. A representative will address your concern. If you are dissatisfied with the outcome of your initial contact, you may file a complaint with our Grievance Unit. If you are not satisfied after filing a formal complaint, you may appeal the decision. Your appeal will be decided in accordance with the procedures applicable to your plan and applicable state laws. All disputes involving denial of payment for a health care service will involve a licensed physician or where appropriate a licensed psychologist, in the same or similar specialty that typically manages or consults on the health care service in question. Refer to your plan documents for further details regarding your plan's complaint procedures.

*This Complaints, Appeals and External Review Process may not apply if your plan is self-funded. Contact your Benefits Administrator if you have any questions.

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 Aetna internal coverage decision review process is 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.

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

Medical Emergency is defined as the existence of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention to result in:

(1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; (2) serious impairment of bodily functions; or (3) serious dysfunction of any bodily organ or part.

You are covered for emergency services 24 hours a day, anywhere in the world, provided the service is a covered benefit and is medically necessary. In an emergency, it is not necessary to call your PCP or Aetna prior to receiving care. Aetna covers emergency care screening and stabilization for conditions that reasonably appear to constitute an emergency, based on your presenting symptoms. Also covered is emergency transportation and related emergency services provided by a licensed ambulance service. Prior authorization is not required for emergency medical care.

You will be reimbursed for the cost of emergency services rendered by a non-participating provider located either within or outside the service area, for those expenses, less copayments, which are incurred up to the time the member is determined by Aetna and the attending physician to be medically able to travel or to be transported to a participating provider. In the event that transportation is medically necessary, the member will be reimbursed for the cost as determined by Aetna Health, less any applicable copayments. Reimbursement may be subject to payment by the member of all copayments which would have been required had similar benefits been provided during office hours and upon prior referral to a participating provider.

On occasion you may need nonemergency care after office hours. Your PCP is on call 24 hours a day, 365 days a year, and is available after regular office hours, either through an answering service or through another physician who is taking patient calls. In urgent care situations, you should call your PCP for instructions before seeking medical care. Your PCP may advise you to seek emergency room care, direct you to an urgent care facility, or advise you that care can wait until regular office hours.

Diabetic Coverage

Aetna covers diabetic equipment and supplies and medically necessary physician visits, as well as outpatient self management and training, including information on proper diet and nutrition, supervised by a licensed health care professional. Covered equipment includes blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar and orthotics. Diabetic self-management and training coverage includes medically necessary physician visits upon the diagnosis of diabetes, visits when a physician identifies a change in the member's self management regimen, and new medications or therapies that the physician considers medically necessary. Applicable physician copayments apply.

Our network is not restricted, and members continue to have access to many other facilities that participate with Aetna.

Provider Directories - Using Our DocFind® Online Provider Directory

Anyone who visits Aetna's website at www.aetna.com can link to our DocFind Online Provider Directory. Visitors to our DocFind Online Provider Directory can search for any type of provider in our database (i.e. physicians, dentists, facilities and vendors, hospitals, Vision One™ providers, behavioral health providers, pharmacies, natural alternatives providers) and other health care professionals. Our DocFind Online Provider Directory is updated three times a week to provide the latest information available about our network of participating providers and health care professionals.

Our DocFind Online Provider Directory displays additional information about participating providers (where available), including whether they are board certified, what medical school they attended, what year they graduated and if they are accepting new patients. Our DocFind Online Provider Directory also displays other office locations in which a provider may see members.

Our DocFind Online Provider Directory contains the most current information available, should you want to obtain a copy of our paper directory, please call the toll-free Member Services number on your ID card or send a secure message to Member Services from www.aetna.com.

Life-Threatening Conditions

Any member with (i) a life-threatening condition or disease or (ii) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request that a specialist or specialty care center assume responsibility for providing or coordinating the member's medical care, including primary and specialty care. A member may make this request through the member's selected PCP. If Aetna Health, or the PCP, in consultation with a medical director of Aetna and specialist, if any, determines that the member's care would most appropriately be coordinated by such a specialist or specialty care center, Aetna will authorize a referral to the specialist or specialty care center.

Aetna is not required to permit a member to elect to have a nonparticipating specialist, unless such a specialist is not available within Aetna network of participating providers. Any authorized referral shall be made pursuant to a treatment plan approved by Aetna in consultation with the PCP (if appropriate), the specialist or specialty care center, the member or the member's designee. The approved specialist or specialty care center will be permitted to treat the member without a referral from the member's PCP and may authorize referrals, procedures, tests and other medical services as the member's PCP would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan. If the member's referral is to a nonparticipating provider, services provided pursuant to the approved treatment plan will be provided at no extra cost to the member beyond what the member would otherwise pay for services received within the Aetna network of participating providers.

For the purposes of this provision, a specialty care center means only centers that are accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

Continuity of Care

If a member's health care provider stops participation with Aetna for reasons other than imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board that impairs the health professional's ability to practice, Aetna will continue coverage for the member to continue an ongoing course of treatment with the member's current health care provider during a transitional period.

Coverage shall continue for up to 90 days from the date of notice to the member of the provider's termination of participation with Aetna or if the member has entered the second trimester of pregnancy, for a transitional period that includes the provision of postpartum care directly related to the delivery. The coverage will be authorized by Aetna for the transitional period only if the health care provider agrees to accept reimbursement at the rates applicable prior to the start of transitional period as payment in full; to adhere to quality standards and to provide medical information related to such care; and to adhere to Aetna policies and procedures. This paragraph shall not be construed to require Aetna to provide coverage for benefits not otherwise covered.

For new members, coverage will be provided for new members to continue an ongoing course of treatment with member's current health care provider for a transitional period of up to 60 days from the effective date of enrollment. If the member has entered the second trimester of pregnancy as of the effective date of enrollment, the transitional period shall include the provision of postpartum care directly related to the delivery. The coverage will be authorized by Aetna for the transitional period only if the health care provider agrees to accept reimbursement rates established by Aetna as payment in full to adhere to Aetna quality standards and to provide medical information related to the care; and to adhere to Aetna policies and procedures. This paragraph shall not be construed to require Aetna to provide coverage for benefits not otherwise covered.

Board of Directors or Officers

You can obtain a list of the names, business addresses and official positions of the membership of the board of directors or officers by writing to:

Aetna Health Inc.
980 Jolly Road
P.O. Box 1109
Blue Bell, Pennsylvania 19422

Physician Credentials

Before physicians are accepted into Aetna network, they are reviewed for licensure and other credentials, quality of care and office standards. Besides their initial review, participating PCPs are also re-reviewed on a regular basis.

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.

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.

Experimental Procedures

A drug, medical device, procedure or treatment will be determined to be experimental if:

- 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
- Required FDA approval has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or

- The written protocol or protocols used by the treating facility or the protocol or protocols of any other facility studying substantially the same drug, medical device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, medical device, procedure or treatment states that it is experimental or for research purposes; or
- It is not of proven benefit for the specific diagnosis or treatment of a member's particular condition; or
- 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
- It is provided or performed in special settings for research purposes.

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.

Participating Provider Information

Participating Providers are not prohibited, limited or restricted from advocating on your behalf or providing information, letters of support to, or assistance consistent with your health care needs and their professional responsibility, conscience, medical knowledge, license and applicable law. In fact, participating providers are encouraged to discuss with you, all pertinent details regarding your condition and all care alternatives, including potential risks and benefits, even if a care option is not a covered benefit under your specific plan documents. Participating providers are encouraged to discuss their compensation arrangements with you. Aetna does not intervene in the manner, methods or means by which your participating provider renders health care services to you.

Quality Enhancement

The Quality Enhancement rewards PCPs for their scores on several measures intended to evaluate the quality of care and services the PCPs provide to members. PCP offices can earn additional compensation for each member each month based on the scores received on one or more of the following measures of the PCP's office: member satisfaction, percentage of members who visit the office at least annually, medical record reviews, the burden of illness of the members that have selected the 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 electronic claims and referral submission program.

Claims Payment for Nonparticipating Providers and Use of Claims Software

If your plan provides coverage for services rendered by nonparticipating providers, you should be aware that Aetna determines the usual, customary and reasonable fee for a provider by referring to commercially available data reflecting the customary amount paid to most providers for a given service in that geographic area 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.

Quality Assurance Program

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:

- routine monitoring of quality of service and care, including:
- the performance of medical chart review audits in the office setting to evaluate the quality of preventive care.
- 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 level, and
- periodic analysis of provider availability and access.
- rigorous provider certification and recertification, as well as quality performance-based physician and facility contracting.
- adoption and use of practice guidelines, including preventive care recommendations.
- Health promotion and wellness programs which proactively seek to identify members who may be considered high-risk, and which offer incentives to members who participate and achieve predetermined goals in fitness, smoking-cessation, and weight loss programs.
- The use of an automated tracking system to monitor member complaints and grievance, which help, identify opportunities to improve service levels.

- Programs to monitor and address potential underutilization, and denial or delay in providing needed services.
- 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.
- 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.

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.

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).

* 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.

Special Enrollment Periods

Due to Loss of Coverage

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

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

- When you declined enrollment for you or your dependent, you stated in writing that coverage under another group health plan or other health insurance was the reason for declining enrollment, if the employer required such written notice and you were given notice of the requirement and the consequences of not providing the statement; and
- When you declined enrollment for you or your dependent, you or your dependent had COBRA continuation coverage under another plan and that COBRA continuation coverage has since been exhausted; or
- If the other coverage that applied to you or your dependent when enrollment was declined was not under a COBRA continuation provision, either the other coverage has been terminated as a result of the loss of eligibility or employer contributions toward that coverage have been terminated. Loss of eligibility includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, or reduction in hours of employment.

For Certain Dependent Beneficiaries

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

Special Enrollment Rules

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

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

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

Special Enrollment Rights

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

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

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

Request for Certificate of Creditable Coverage

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

*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

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.**