

Important Disclosure Information*

For Aetna SelectSM, Open Access Aetna SelectSM and Aetna Choice[®] POS II members.

Plan of Benefits

Your plan of benefits will be determined by your plan sponsor and underwritten or administered by Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, CT 06156. The benefits and main points of the Service Agreement or Group Policy of your plan of benefits will be set forth in the Booklet-certificate or Booklet which will be provided to you at a later date.

Covered services include most types of treatment provided by primary care physicians, specialists and hospitals. However, the health plan excludes or limits 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 necessary as defined in the plan documents and as determined by Aetna**. The information that follows provides general information regarding Aetna plans. Members should consult their plan documents for a complete description of what health care services are covered and any applicable exclusions and limitations.

Member Copays and Deductibles

Your plan of benefits may contain some or all of the following features:

- **Copayments** - These are fees that you must pay for some covered medical expenses.
- **Calendar Year Deductible** - The amount of covered medical expenses you pay each calendar year before benefits are paid. There is a calendar year deductible that applies to each person.
- **Inpatient Hospital Deductible** - This is the amount of covered inpatient hospital expenses you pay for each hospital confinement.
- **Emergency Room Deductible** - A separate hospital emergency room deductible applies to each visit by a person to a hospital emergency room unless the person is admitted to the hospital as an inpatient within 24 hours after a visit to a hospital emergency room.

*Note: Specific plan documents supersede general disclosures contained within, as applicable.

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

The applicability and amount of each copay and deductible listed above will be determined by your plan sponsor and described in your plan documents.

Role of Primary Care Physicians ("PCPs")

Members are required or encouraged 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.

For some services, the PCP is required to obtain prior authorization from Aetna. You may go directly to a provider or facility for covered services, you will generally be responsible for a deductible and coinsurance in these circumstances. Even so, you may be able to reduce your out-of-pocket expenses considerably by using the participating providers listed in the Provider Directory. Additionally, you may go directly to a participating specialist without a referral from your PCP, and pay the applicable copay. Please refer to your plan documents for details.

Referral Policy

If your plan requires referrals to obtain maximum benefits, the following points are important to remember:

- 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 services, 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 approval 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.

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- Referrals are valid for 60 days as long as the individual remains an eligible member of the plan
- Coverage for services from non-participating providers requires prior approval by Aetna in addition to a special non-participating referral from the PCP (if required by your plan). When properly authorized, these services are fully covered, less the applicable copay.
- The referral provides that, except for an applicable copay, the member will not have to pay the charges for covered services, as long as the individual is a member at the time the services are provided.

If your plan does not specifically cover non-preferred benefits and you go directly to a specialist or hospital for non-emergency 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.

Ob/Gyn Program

Female members have direct access to participating Ob/Gyns for covered obstetric and gynecologic services. This program allows female members to visit any participating gynecologist for a routine well-woman exam, including a Pap smear and for gynecologic problems. Gynecologists may also refer a woman directly to other participating providers for covered gynecologic services. All health plan preauthorization and coordination requirements continue to apply.

Transplants and Other Complex Conditions

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

Emergency Care

If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world. An emergency medical condition is one manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child.

Whether you are in or out of an Aetna 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 within 48 hours of the start of confinement as a full-time inpatient (72 hours if the confinement starts on a Friday or Saturday) or as soon as reasonably possible.

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 Pharmacy 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

If your plan through Aetna includes coverage for behavioral health care services, certain of these services are managed by an independently contracted behavioral health care organization. For example, 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.

If your plan includes behavioral health care services, you can receive information regarding the appropriate way to access behavioral health care services that are covered under your specific plan by calling the Behavioral Health Vendor toll-free number on your ID card or, if there is not a specific number listed, call the Member Services number on your ID card for the appropriate information. As with other coverage determinations, you may appeal adverse behavioral health care coverage determinations in accordance with the provisions of your health plan and/or applicable state law.

How Aetna Compensates Your Physician and Other Providers

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

Participating physicians, hospitals and other providers in our network are compensated in various ways for the services covered under your plan.

- Per individual service or case (fee for service at contracted rates).
- Per hospital day (per diem contracted rates).

Non-participating providers providing covered services are reimbursed on a fee-for-service basis.

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

Claims Payment for Non-participating Providers and Use of Claims Software

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

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 and Necessary Services

Precertification is the process of collecting information prior to inpatient admissions and performance of selected ambulatory procedures and services. The process permits advance determination of the medical necessity and appropriateness of the procedures and services from a coverage perspective, and communication with the physician and/or member. It also allows Aetna to coordinate the patient's transition from the inpatient setting to the next level of care (discharge planning), or to register patients for specialized programs like disease management, case management, or our prenatal program.

In some instances, precertification is used to inform physicians, members and other health care providers about cost-effective programs and alternative therapies and treatments.

Certain health care services, such as hospitalization or outpatient surgery, require precertification with Aetna to obtain coverage for those services. When a member is to obtain services requiring precertification through a participating provider, this provider should precertify those services prior to treatment. If your plan covers out-of-network benefits and you may self-refer for covered services, it is your responsibility to contact Aetna to precertify those services which require precertification.

You must obtain precertification for certain types of care rendered by non-preferred providers to avoid a reduction in benefits paid for that care. Refer to your plan documents for specific information. Only medically necessary services are covered. A service or supply furnished by a particular provider is medically necessary if Aetna determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

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, [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.

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

Complaints, Appeals and External Review*

Filing a Complaint or Appeal

Aetna is committed to addressing members' coverage issues, complaints and problems. If you have a coverage issue or other problem, call Member Services at the toll-free number on your ID card. You can also contact Member Services through the Internet at www.aetna.com. If Member Services is unable to resolve your issue to your satisfaction, it will be forwarded to the appropriate department for handling.

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

External Review

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

An independent review organization (IRO) will assign the case to a physician reviewer with appropriate expertise in the area in question. After all necessary information is submitted, an external review generally will be decided within 30 calendar days of the request. Expedited reviews are available when a member's physician certifies that a delay in service would jeopardize the member's health. Once the review is complete, the plan will abide by the decision of the external reviewer. The cost for the review will be borne by Aetna (except where state law requires members to pay a filing fee as part of the state mandated program).

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

*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.

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, and 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)

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).

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.

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.

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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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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, 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. The Aetna company that underwrites or administers benefits coverage includes Aetna Life Insurance Company. For self-funded accounts, coverage is 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.**