

Important Disclosure Information

For Traditional Choice® Indemnity Plans.

State mandates do not apply to self-funded plans governed by ERISA. If you are unsure if your plan is self-funded and/or governed by ERISA, see your benefits administrator.

Plan Benefits

Your plan of benefits is determined by your plan sponsor. The plan your employer chooses is underwritten or administered by Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, CT 06156, 1-888-982-3862. Covered services include most types of treatment provided by primary care physicians, specialists and hospitals. However, a health plan excludes and/or includes limits on coverage for some services, including but not limited to, cosmetic surgery and experimental procedures. In addition, in order to be covered, all services, including the location (type of facility), duration and costs of services, must be medically necessary as defined below and as determined by Aetna. The information that follows provides general information regarding Aetna health plans. For a complete description of the benefits available to you, including procedures to follow, exclusions and limitations, refer to your specific plan documents, which may include the Booklet-certificate, Group Agreement, Group Insurance Certificate, Group Policy and any applicable riders and amendments to your plan.

Member Cost Sharing

Cost sharing refers to the portion of medical services that you pay out of your own pocket. Refer to your plan documents to see which of the following cost-sharing provisions apply to your plan:

- Copay – This may be a flat fee that you pay directly to the health care provider at the time of service.
- Coinsurance – This is a percentage of the fees that you must pay toward the cost of some covered medical expenses. Your health care provider will bill you for this amount.
- 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 – The amount of covered inpatient hospital expenses you pay for each hospital confinement before benefits are paid. This deductible is *in addition to* any other copayments or deductibles under your plan.
- Emergency Room Deductible – The amount of covered hospital emergency room expenses you pay each year before benefits are paid. 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.

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

Precertification

Some health care services, like hospitalization and certain outpatient surgery, require “precertification.” This means the service must be approved by Aetna before it will be covered under the plan. Check your plan documents for a complete list of services that require this approval. When reviewing a precertification request, we will verify your eligibility and make sure the service is a covered expense under your plan. We also check the cost-effectiveness of the service and we may communicate with your doctor if necessary. If you qualify, we may enroll you in one of our case management programs and have a nurse call to make sure you understand your upcoming procedure.

It is your responsibility to make sure the service is precertified, so be sure to talk to your doctor about it. If you do not get proper authorization for services, you may have to pay for the service yourself.

You cannot request precertification after the service is performed. To precertify services, call the number shown on your Aetna ID card. When properly authorized, these services are fully covered, less the applicable cost sharing.

Advance Directives

There are three types of advance directives:

- Durable power of attorney – appoints someone you trust to make medical decisions for you.
- Living will – spells out the type and extent of care you want to receive.
- Do-not-resuscitate order – states that you don't want to be given CPR if your heart stops or be intubated if you stop breathing.

You can create an advance directive in several ways:

- Get an advance medical directive form from a health care professional. Certain laws require health care facilities that receive Medicare and Medicaid funds to ask all patients at the time they are admitted if they have an advance directive. You don't need an advance directive to receive care. But we are required by law to give you the chance to create one.
- Ask for an advance directive form at state or local offices on aging, bar associations, legal service programs, or your local health department.
- Work with a lawyer to write an advance directive.
- Create an advance directive using computer software designed for this purpose.
- If you are not satisfied with the way Aetna handles advance directives, you can file a complaint with your Medicare State Certification Agency. Visit www.medicare.gov for information on specific state agencies or call 1-800-MEDICARE (1-800-633-4227) (TTY/TDD: 1-877-486-2048).

Source: American Academy of Family Physicians. *Advanced Directives and Do Not Resuscitate Orders*. January 2009. Available at <http://familydoctor.org/003.xml?printxml>. Accessed February 20, 2009.

Transplants and Other Complex Conditions

Our National Medical Excellence Program® and other specialty programs help you access covered services 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, you may be limited to only those facilities participating in these programs when needing a transplant or other complex condition covered.

Note: There are exceptions depending on state requirements.

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 person, 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 doctor or PCP. Notify your doctor or 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 doctor, PCP or Aetna as soon as 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 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 you pay to your pharmacy for a prescription drug. In addition, in circumstances where your prescription plan utilizes copayments or coinsurance calculated on a percentage of the cost of a drug or a deductible, it is possible for your cost to be higher for a preferred drug than it would for a nonpreferred drug. For information regarding how medications are reviewed and selected for the preferred drug list, please refer to 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. For more information, call Member Services at the toll-free number on your 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 you to use such drugs, your physician, you or your authorized representative (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 that requires a trial of one or more "prerequisite-therapy" medications before a "step-therapy" medication will be covered. If it is medically necessary for you to use a medication subject to these requirements prior to completing the step therapy, your physician, you or your authorized representative 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.

Ask your treating physician(s) 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 Aetna Rx Home Delivery® mail-order prescription program or the Aetna Specialty Pharmacy® specialty drug program, you will be acquiring these prescriptions through an affiliate of Aetna. Aetna Rx Home Delivery's and Aetna Specialty Pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts they may receive from wholesalers, manufacturers, suppliers and distributors. The negotiated charge with Aetna Rx Home Delivery, LLC. and Aetna Specialty Pharmacy may be higher than the cost of purchasing drugs and providing pharmacy services.

Updates to the Drug Formulary

For up-to-date formulary information, visit www.aetna.com/formulary/ or call Member Services at the toll-free number on your Aetna ID card. If you do not have Internet access, you may contact Member Services at the toll-free number on your ID card to find out how a specific drug is covered.

Behavioral Health Provider Safety Data Available

For information about our Behavioral Health provider network safety data, visit www.aetna.com/docfind and select the "Get info on Patient Safety and Quality" link. If you do not have Internet access, you may call Member Services at the toll-free number shown on your Aetna ID card to request a printed copy of this information.

Behavioral Health Depression Prevention Programs

Aetna Behavioral Health offers two prevention programs for our members: Perinatal Depression Education, Screening and Treatment Referral Program, also known as Beginning Right® Depression Program, and Identification and Referral of Adolescent Members Diagnosed With Depression Who Also Have Comorbid Substance Abuse Needs. For more information on either of these prevention programs and how to use the programs, ask Member Services for the phone number of your local Care Management Center.

How Aetna Pays Providers

Some of our plans pay for services from providers who are not in our network. Many plans pay for services based on what is called the "reasonable," "usual and customary" or "prevailing" charge. Other plans pay based on a percentage of Medicare's fees or a specific fee schedule.

When we pay less than what your provider charges, your provider may require you to pay the difference. This is true even if you have reached your plan's out-of-pocket maximum. Here is how we figure out what we will pay for each type of plan.

Prevailing Charge Plans

Step 1: We review the data.

We get information from Ingenix, which is owned by United HealthCare. Health plans send Ingenix copies of claims for services they received from providers. The claims include the date and place of the service, the procedure code, and the provider's charge. Ingenix combines this information into databases that show how much providers charge for just about any service in any zip code.

Step 2: We calculate the portion we pay.

For most of our health plans, we use the 80th percentile to calculate how much to pay for out-of-network services.

Payment at the 80th percentile means 80 percent of charges in the database are the same or less for that service in a particular zip code.

If there are not enough charges (less than 9) in the databases for a service in a particular zip code, we may use "derived charge data" instead. "Derived charge data" is based on the charges for comparable procedures, multiplied by a factor that takes into account the relative complexity of the procedure that was performed. We also use derived charge data for our student health plans and Aetna Affordable Health Choices® plans.

We also may consider other factors to determine what to pay if a service is unusual or not performed often in your area. These factors can include:

- The complexity of the service
- The degree of skill needed
- The provider's specialty
- The prevailing charge in other areas
- Aetna's own data

Step 3: We refer to your health plan.

We pay our portion of the prevailing charge as listed in your health plan. You pay your portion (called "coinsurance") and any deductible.

For example, your out of network doctor charges \$120 for an office visit. Your plan covers 70 percent of the "reasonable," "usual and customary" or "prevailing" charge. Let's say the prevailing charge is \$100. And let's say you already met your deductible. Aetna would pay \$70. You would pay the other \$30. Your doctor may also bill you for the \$20 difference between the prevailing charge (\$100) and the billed charge (\$120). In this case, your doctor could bill you for a total of \$50.

The Prevailing Charge Databases

The New York State Attorney General (NYAG) investigated the conflicts of interest related to the ownership and use of Ingenix data. Under an agreement with the NYAG, UnitedHealth Group agreed to stop using the Ingenix databases when an independent database (not owned by a health insurer) is created. In a separate agreement with NYAG in January 2009, Aetna agreed to use this new database when it is ready. We also will work with the new database owner to create online tools to give you better information about the cost of your care when using providers outside our network.

Exceptions

Some "prevailing charge" plans set the prevailing charge at a different percentile. For some claims (like those from hospitals and outpatient centers) we may use other information and data sources to determine the charge.

And some of our plans pay based on a fee schedule. Also, for some non-participating providers we may pay based on other contractual arrangements.

Our provider claims codes and payment policies may also affect what we pay for a claim. Aetna may 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. The effects of these policies will be reflected in your Explanation of Benefits documents.

Technology Review

We review new medical technologies, behavioral health procedures, pharmaceuticals and devices to determine which ones should be covered by our plans. And we even look at new uses for existing technologies. To review these innovations, we may:

- Study published medical research and scientific evidence on the safety and effectiveness of medical technologies.
- Consider position statements and clinical practice guidelines from medical and government groups, including the federal Agency for Health Care Research and Quality.
- Seek input from relevant specialists and experts in the technology.
- Determine whether the technologies are experimental or investigational.

You can find out more on new tests and treatments in our Clinical Policy Bulletins. See Clinical Policy Bulletins below for more information.

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:

- In accordance with generally accepted standards of medical practice; and
- Clinically appropriate in accordance with generally accepted standards of medical practice in terms of type, frequency, extent, site and duration, and considered effective for the illness, injury or disease; and
- Not primarily for the convenience of you, 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.

For these purposes “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, or otherwise consistent with physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Clinical Policy Bulletins

Clinical Policy Bulletins (CPBs) describe our policy determinations of whether certain services or supplies are medically necessary or experimental or investigational, based on 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 CPBs do not constitute medical advice. Treating providers are solely responsible for medical advice and for your treatment. You should discuss any CPB related to your coverage or condition with your treating provider. While Aetna 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. You and your providers will need to consult the 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 CPBs are available at www.aetna.com under “Members” and then “Health Coverage Information.” If you do not have Internet access, please contact Member Services at the toll-free number on your ID card for information about specific Clinical Policy Bulletins.

Utilization Review/Patient Management

We have 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 you in receiving appropriate health care and maximizing coverage for those health care services. You can avoid receiving an unexpected bill with a simple call to Member Services. You can find out if your preventive care service, diagnostic test or other treatment is a covered benefit — before you receive care — just by calling the toll-free number on your ID card. In certain cases, we review your request to be sure the service or supply is consistent with established guidelines and is a covered benefit under your plan. We call this “utilization management review.”

We follow specific rules to help us make your health a top concern:

- Aetna employees are not compensated based on denials of coverage.
- We do not encourage denials of coverage. In fact, our utilization review staff is trained to focus on the risks of members not adequately using certain services.

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

Only medical professionals 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 you of the appeal process. For more information concerning utilization management, you may request a free copy of the criteria we use to make specific coverage decisions by contacting Member Services.

You may also visit

www.aetna.com/about/cov_det_policies.html to find our Clinical Policy Bulletins and some utilization review policies. Doctors or health care professionals who have questions about your coverage can write or call our Patient Management department. The address and phone number are on your ID card.

Concurrent Review

Concurrent review is a review conducted while a patient is confined on an inpatient basis. 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 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 that may be utilized by you upon discharge from an inpatient stay.

Retrospective Record Review

Retrospective review is a review conducted after the patient has been discharged from the hospital or facility. The purpose of retrospective review is to 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 health care services. Our effort to manage the services provided to you 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

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.

Filing a Complaint or Appeal

We are committed to addressing your 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 or e-mail us from your secure Aetna Navigator® member website. Click on “Contact Us” after you log on. You can also contact Member Services 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. Your appeal will be decided in accordance with the procedures applicable to your plan and applicable state law. Refer to your plan documents for details regarding your plan's appeal procedure.

About Coverage Decisions

Sometimes we receive claims for services that may not be covered by your health benefits plan. It can be confusing — even to your doctors. Our job is to make coverage decisions based on your specific benefits plan.

If a claim is denied, we'll send you a letter to let you know. If you don't agree you can file an appeal. To file an appeal, follow the directions in the letter that explains that your claim was denied. Our appeals decisions will be based on your plan provisions and any state and federal laws or regulations that apply to your plan. You can learn more about the appeal procedures for your plan from your plan documents.

External Review

We established an external review process to give you the opportunity of requesting an objective and timely independent review of certain coverage denials. Once the applicable internal appeal process has been exhausted, you may request an external review of the decision for the coverage denial if: (a) you would be financially responsible

for the cost of services; (b) the amount of the service(s) is more than \$500, and (c) is based on lack of medical necessity or on the experimental or investigational nature of the proposed service or supply. Standards may vary by state, and several states have external review processes that may apply to your plan.

If a request meets the requirement for an external review, an Independent Review Organization (IRO) will assign the case to an external physician reviewer with appropriate expertise for an independent decision 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 your physician certifies that a delay in service would jeopardize your 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 you to pay a filing fee as part of a state mandated program).

Certain states mandate external review of additional benefit or service issues; some may require a filing fee. In addition, certain states mandate the use of their own external review process for medical necessity and experimental or investigational coverage decisions. These state mandates may not apply to self-funded plans.

For details about 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 www.aetna.com to print an external review request form, or call the Member Services toll-free number on your ID card. You also may call your state insurance or health department or consult their websites for additional information regarding state mandated external review procedures.

Member Rights & Responsibilities

You have the right to receive a copy of our Member Rights and Responsibilities Statement. This information is available to you at www.aetna.com/about/MemberRights. You can also obtain a print copy by contacting Member Services at the number on your ID card.

Member Services

To file a complaint or an appeal, for additional information regarding copayments and other charges, information regarding benefits, to obtain copies of plan documents, information regarding how to file a claim or for any other question, you can contact Member Services at the toll-free number on your ID card, or email us from your secure Aetna Navigator member website at www.aetna.com. Click on “Contact Us” after you log on.

Spanish-speaking hotline – 1-800-533-6615

Multilingual hotline – 1-888-982-3862 (140 languages are available. You must ask for an interpreter.)

Interpreter/Hearing Impaired

When you require assistance from an Aetna representative, call us during regular business hours at the number on your ID card. Our representatives can:

- Answer benefits questions
- Help you get referrals
- Find care outside your area
- Advise you on how to file complaints and appeals
- Connect you to behavioral health services (if included in your plan)
- Find specific health information
- Provide information on our Quality Management program, which evaluates the ongoing quality of our services

TDD Member Services – 1-800-628-3323 (hearing impaired only)

Quality Management Programs

We have a comprehensive quality measurement and improvement strategy, and do not view it as an isolated, departmental function. Rather, we integrate quality management and metrics into all that we do. For details on our program, goals and our progress on meeting those goals, go to www.aetna.com/members/health_coverage/quality/quality.html. If you do not have Internet access and would like a hard copy of the information referenced here, please contact Member Services at the toll-free number on your ID card and request a copy.

Privacy Notice

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 your physical or mental health or condition, the provision of health care to you, or payment for the provision of health care to you. 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 you.

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 anti-fraud activities; performance measurement and outcomes assessment; health claims analysis and reporting; health services research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health plans. To the extent permitted by law, we use and disclose personal information as provided above without your consent. However, we recognize that you may not want to receive unsolicited marketing materials unrelated to your health benefits. We do not disclose personal information for these marketing purposes unless you consent. We also have policies addressing circumstances in which you are unable to give consent.

To request a printed 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 Legal Support Services Department
151 Farmington Avenue, W121
Hartford, CT 06156

You can also visit www.aetna.com and link directly to the Notice of Privacy Practices by selecting the "Privacy Notices" link at the bottom of the page.

Non-discrimination statement

Aetna does not discriminate in providing access to health care services on the basis of race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national origin. We are required to comply with Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, other laws applicable to recipients of federal funds, and all other applicable laws and rules.

www.aetna.com

Use of Race, Ethnicity and Language Data

Aetna members have the option to provide us with race/ethnicity and preferred language information. This information is voluntary and confidential. We collect this information to identify, research, develop, implement and/or enhance initiatives to improve health care access, delivery and outcomes for diverse members, and otherwise improve services to our members. We will maintain administrative, technical and physical safeguards to protect information concerning member race, ethnicity and language preference from inappropriate access, use or disclosure. This data will be collected, used or disclosed only in accordance with Aetna policies and applicable state and federal requirements. It is not used to determine eligibility, rating or claim payment.

For more information, please visit www.aetna.com. If you do not have Internet access and would like a hard copy of the information referenced here, please contact Member Services at the toll-free number on your ID card and request a copy.

State Variations

Note: State benefits mandates may not apply to self-insured plans. Contact Member Services with specific questions about your coverage. In some states, Aetna provides additional consumer disclosures in documents also posted on our website at www.aetna.com.

Colorado

To obtain reimbursement rates for nonparticipating providers, you may contact Member Services at the number listed on your ID card.

Colorado law requires carriers to make available a Colorado Health Benefit Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular plan or who has selected the plan as a finalist from which the ultimate selection will be made. The carrier also must provide the form, upon oral or written request, within three (3) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier.

COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFITS PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2-50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFITS PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW.

In accordance with Colorado law, Aetna has established open enrollment periods for guarantee issue basic or standard plan applications from business groups of one. The open enrollment period is a period of 31 days following the birth date of the person qualifying as a business group of one. Issuance of a basic health benefit plan and a standard health benefit plan is limited to such thirty-one day period. A copy of the applicant's driver's license or birth certificate must be provided as evidence of the applicant's birth date. In addition to the annual 31 day enrollment period, persons qualifying as business groups of one may apply within 31 days of the date of the following events: (1) the end of state or federal continuation coverage; (2) the person initially meets the business group of one definition requirements and whose birth date is more than 31 days after doing so; or (3) the person involuntarily loses other creditable

coverage. (This event (3) does not apply in cases of failure to pay premium, fraud, or a voluntary decision on the part of the person to terminate other creditable coverage.

Renewability

This coverage is renewable at your option, except for the following reasons:

- Nonpayment of premiums
- Fraud or intentional misrepresentation of material fact on the part of the plan sponsor with respect to group health benefit plan coverage and the individual with respect to individual coverage
- Violation of participation or contribution rules
- The carrier elected to discontinue offering and nonrenew all of its individual, small group or large group plans delivered or issued for delivery in Colorado
- With respect to small group health plans, an employer is no longer actively engaged in the business in which it was engaged on the effective date of the plan
- For network plans, there are no longer any enrollees who reside or work in the service area
- If the employer's membership in a bona fide association ceases, but only if coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual

Connecticut

Religious Exemption

As permitted under Connecticut law, an insurer may issue to a religious employer a policy that excludes coverage for infertility treatment that is contrary to the religious employer's beliefs.

Some of these treatments may include:

- Ovulation induction (OI)
- Intrauterine insemination
- In-vitro fertilization (IVF)
- Embryo transfer
- Gamete intra-fallopian transfer (GIFT)
- Zygote intra-fallopian transfer (ZIFT)
- Low tubal ovum transfer
- Uterine embryo lavage

Delaware

Mandated Benefit - Scalp Hair Prosthesis:

Aetna will provide coverage for expenses for a scalp hair prosthesis worn for hair loss suffered as a result of alopecia areata, resulting from an autoimmune disease. The same limitations and guidelines that apply to other prosthesis as outlined in your Benefit Plan will apply but coverage for scalp hair prosthesis as a result of alopecia areata will not exceed \$500 per year.

Delaware Insurance Department

You have the right to seek review of a claim denial through the Delaware Insurance Department. The Delaware Insurance Department also provides free informal mediation services, which are in addition to, but do not replace, your right to a review of the decision. You can contact the Delaware Insurance Department for information about claim denial review or mediation by calling the Consumer Services Division at 1-800-282-8611 or 302-739-4251. You may go to the Delaware Insurance Department at The Rodney Building, 841 Silver Lake Blvd., Dover, DE 19904 between the hours of 8:30 a.m. and 4:00 p.m. to personally discuss the review or mediation process.

All requests for review through procedures established by the Delaware Insurance Department must be filed within 60 days from the date you receive your decision notice; otherwise the decision will be final.

Hawaii

Informed Consent

You have the right to be fully informed prior to making any decision about any treatment, benefit, or nontreatment.

Your provider will:

- Discuss all treatment options, including the option of no treatment at all
- Ensure that persons with disabilities have an effective means of communication with the provider and other members of the managed care plan
- Discuss all risks, benefits, and consequences of treatment and nontreatment

Your provider will also discuss with you and your immediate family both living wills and durable powers of attorney in relation to medical treatment.

Insurance Division Telephone Number:

You may contact the Hawaii Insurance Division and the Office of Consumer Complaints at 1-808-586-2790.

Kentucky

Emergency Medical Condition Definition

A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson would reasonably have cause to believe

constitutes a condition that the absence of immediate medical attention could reasonably be expected to result in: placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, a situation in which there is inadequate time to effect a safe transfer to another hospital before delivery; or a situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.

Louisiana

Aetna will not in any way use the results of genetic testing to discriminate against applicants or enrollees.

Maryland

Experimental Medical Treatment

Aetna supports physician requests for experimental treatment for life threatening illness:

- When there is disease progression after conventional treatment
- When there is no conventional treatment and the proposed treatment is delivered
- Under Institutional Review Board (IRB) supervision
- As part of a clinical trial to advance science

This policy supports all phases of clinical trials, including Phase I studies. Each request for such services is evaluated by the National Medical Excellence Unit.

For quality of care issues and life and health care insurance complaints you may contact:

Mid-Atlantic Regional Unit
980 Jolly Road,
P.O. Box 935
Blue Bell, PA 19422

or

Maryland Insurance Administration Life and Health Insurance Complaints
200 Saint Paul Place, Suite 2700
Baltimore, Maryland 21202-2272
Telephone: 1-800 492-6116 (toll free) or;
Phone: 410-468-2244
Facsimile: 410-468-2243

For assistance in resolving a billing or payment dispute with the health plan or a health care provider you may contact:

Mid-Atlantic Regional Unit
980 Jolly Road
P.O. Box 935
Blue Bell, PA 19422

or

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General, 16th Floor
200 Saint Paul Place
Baltimore, MD 21202
Telephone: 410-528-1840
Facsimile: 410-576-7040

Nothing herein shall be construed to require Aetna to pay counsel fees or any other fees or costs incurred by a member in pursuing a complaint or appeal.

New Jersey

Infertility Benefits (This mandate only applies to groups of 51 or more members):

New Jersey mandates certain infertility benefits. Your employer as permitted by law can elect not to provide coverage for the following procedures because they conflict with their bona fide religious tenets:

- In vitro fertilization (IVF)
- Embryo transfers
- Artificial insemination
- Zygote intra fallopian transfer (ZIFT)
- Gamete intra fallopian transfer (GIFT)
- Intracytoplasmic sperm injection (ICSI)

Please refer to your plan administrator for specifics regarding your benefits.

Mastectomy Coverage Information

Your plan will provide coverage for a minimum of 72 hours of inpatient care following a modified radical mastectomy and a minimum of 48 hours of inpatient care following a simple mastectomy.

A shorter stay is allowable if the patient and the patient's physician determine it is medically appropriate. The policy does not require a health care provider to obtain authorization from the insurer for prescribing the minimum 72 or 48 hours of inpatient care.

North Carolina

Experimental Treatment Information

Procedures and medically based criteria for determining whether a specified procedure, test or treatment is experimental, are available upon request.

Rhode Island

Women's Health

Your Aetna health plan provides benefits for mastectomy and mastectomy-related services, including reconstruction and surgery to achieve symmetry between breasts; prosthesis; and treatment of physical complications of all stages of mastectomy, including lymph edemas.

Coverage is provided in accordance with your plan design, and is subject to plan limitations, copays, deductibles and coinsurance, if any, as outlined in the plan documents you received when you enrolled. For more information please contact Member Services at the number listed on your ID card.

South Dakota

In South Dakota, "concurrent review" is defined as a utilization review conducted during a patient's hospital stay or course of treatment in a facility or other inpatient or outpatient health care setting.

Virginia

Important Information Regarding Your Insurance

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance or if you have additional questions, you may contact the insurance company issuing this insurance at the toll-free number on your Aetna ID card.

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Life and Health Division Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Phone: 804-371-9691
Fax: 804-371-9944

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

West Virginia

Religious Exemption

West Virginia Legislation mandates that group insurance policies and contracts that provide coverage for prescription drugs must include a rider providing coverage for contraceptive drugs and devices that are approved by the FDA or generics approved as substitutes by the FDA. However, "Religious Employers," as defined in the law, may elect not to include this coverage under their policy or contract. If a Religious Employer elects not to provide coverage for contraceptives, each member/enrollee covered under the contract is eligible to obtain a contraceptive rider directly from Aetna. Please refer to your plan administrator for specifics regarding your benefits.

Health Insurance Portability and Accountability Act

The following information is provided to inform you of certain provisions contained in the Group Health Plan, and related procedures that may be utilized by you 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 to 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 to 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 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

If you are a member of an insured plan sponsor or a member of a self-insured plan sponsor who have contracted with us to provide Certificates of Prior Health Coverage, you have the option to request a certificate.

This applies to you if you are a terminated member, or are a member who is currently active but would like a certificate to verify your status. As a terminated member,

you can request a certificate for up to 24 months following the date of your termination. As an active member, you can request a certificate at any time. To request a Certificate of Prior Health Coverage, please contact Member Services at the telephone number listed on your ID card.

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, coverage will be provided to a person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy for:

- (1) reconstruction of the breast on which a mastectomy has been performed;
- (2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
- (3) prostheses; and
- (4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

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.

Health benefits and health insurance plans are underwritten or administered by Aetna Life Insurance Company. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Information subject to change.

The NCQA Accreditation Seal is a recognized symbol of quality. The seal, located on the front cover of your Physician Directory, signifies that your plan has earned this accreditation for service and clinical quality that meets or exceeds the NCQA's rigorous requirements for consumer protection and quality improvement. The number of stars on the seal represents the accreditation level the plan has achieved.

Health care providers who have been duly recognized by the NCQA Recognition Programs are annotated in the Physician Directory. Providers, in all settings, achieve recognition by submitting data that demonstrates they are providing quality care. The program constantly assesses key measures that were carefully defined and tested for their relationship to improved care, therefore, NCQA provider recognition is subject to change. For up-to-date information, please visit our DocFind® directory at www.aetna.com or, if applicable, visit the NCQA's new top-level recognition listing at www.ncqa.org/tabid/58/Default.aspx. If you do not have access to the Internet and would like a printed physician directory, please contact Member Services at the toll-free number shown on your Aetna ID card.