



# Important Disclosure Information

## Traditional Choice®, indemnity plan members.

### Plan of Benefits

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

**Warning:** If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

### Member Cost Sharing

You are responsible for any copayments, coinsurance and deductibles for covered services. These obligations are paid directly to the provider or facility at the time service is rendered. Copayments, coinsurance and deductible amounts are listed in your plan design or benefits summary.

### Patient Management Program

Aetna evaluates and determines the appropriateness of medical care resources utilized by our members. To accomplish these goals, Aetna has developed a comprehensive Patient Management Program. The population demographics of the membership and the program's results are reviewed to determine the need for changes. Regional medical directors in concert with local market medical directors review this information to initiate new program development or enhancement to current programs. The Patient Management Program is reviewed annually.

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

- **Certification**

You must obtain certification for certain types of care to avoid a reduction in benefits paid for that care.

To request certification, you must call the number shown on your ID card. Certification must be obtained before care is received, or in the case of an emergency admission, procedure or treatment, within 48 hours after the start of a confinement as a full-time inpatient or the performance of the procedure or treatment, or as soon as reasonably possible.

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

## Behavioral Health

Certain behavioral health care services (e.g., treatment or care for mental disease or illness, alcohol abuse and/or substance abuse) may be managed by an independently contracted organization. This organization makes initial coverage determinations and coordinates referrals; any behavioral health care referrals will generally be made to providers affiliated with the organization, unless your needs for covered services extend beyond the capability of these providers.

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

## Claim Payment and Use of Claim Software

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 the manner of billing. You are responsible for any charges Aetna determines are not covered under your plan.

## Prescription Drugs

If your plan covers outpatient prescription drugs, your plan may include a drug formulary. A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan subject to applicable limitations and conditions. The medications listed on the formulary are subject to change in accordance with applicable state law. In evaluating clinically and therapeutically similar drugs for selection for the formulary, Aetna reviews the costs of drugs and takes into account rebates negotiated between Aetna and drug manufacturers. Consequently, a drug may be included on the formulary that is more expensive than a non-formulary alternative before any rebates Aetna may receive from a drug manufacturer are taken into account. In addition, certain drugs may be chosen for formulary status because of their clinical or therapeutic advantages or level of acceptance among physicians even though they cost more than non-formulary alternatives. The net cost to a self-funded plan sponsor for covered prescriptions will vary based on (i) the terms of Aetna's arrangements with participating pharmacies; (ii) the amount of the member's copayment, coinsurance or deductible obligation under the terms of the plan; and (iii) the percentage, if any, of rebates to which the plan sponsor is entitled under its agreement with Aetna.

As a result, a self-funded plan sponsor's actual claim expense per prescription for a particular formulary drug may in some circumstances be higher than for a non-formulary alternative. For additional information regarding how medications are reviewed and selected for the formulary, please refer to the Aetna Medication Formulary Guide. A printed copy of the Formulary Guide will be provided, upon request or if applicable, annually for current members and upon enrollment for new members. Additional copies can be obtained by calling Member Services at the toll-free number listed on your member ID card and current Formulary Guide information is available by accessing our website at [www.aetna.com](http://www.aetna.com). Many drugs listed on the formulary are subject to manufacturer rebate arrangements between Aetna and the manufacturer of the drugs. Your pharmacy benefit is not limited to the drugs listed on the formulary. Medications that are not listed on the formulary may be covered subject to the limits and exclusions set forth in your plan documents. Covered prescription drugs not listed on the formulary may be subject to higher copayments under some benefit plans. In prescription plans with copayment or coinsurance tiers, use of formulary drugs generally will result in lower costs to members. However, where the prescription plan utilizes copayments or coinsurance calculated on a percentage basis, there could be some circumstances in which a formulary drug would cost the member more than a non-formulary drug because (i) the negotiated pharmacy payment rate for the formulary drug may be more than the negotiated pharmacy payment rate for the non-formulary drug, and (ii) rebates received by Aetna from drug manufacturers are not reflected in the cost of a prescription drug obtained by a member. Some pharmacy benefit plans may exclude certain drugs not listed on the formulary from coverage. 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. 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, depending on the benefit plan selected by your plan sponsor. Check your plan documents for details. In addition, certain drugs may require precertification or step therapy 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. Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and conditions of coverage.

If you use the mail order prescription services provided by Aetna Rx Home Delivery, you will be acquiring these prescriptions through an affiliate of Aetna.

## Complaint and Appeals Procedure

Our complaints and appeals process is designed to address member coverage issues, complaints and problems. If you have a coverage issue or other problem, call the Member Services toll-free number on your ID card.

You can also contact Member Services at [www.aetna.com](http://www.aetna.com) for more information. A representative will address your concern. If you are dissatisfied with the outcome of your initial contact, you may appeal 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 details regarding your plan's complaint and appeals procedures.

## Confidentiality

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 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 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 copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at [www.aetna.com](http://www.aetna.com).

## Other Disclosures

**Note: Some states require additional disclosures as follows. This information may not apply to employer-funded plans. Contact Member Services with specific questions about your coverage.**

### Louisiana

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

### Michigan

#### **Intractable Pain Coverage**

Aetna provides benefits for the evaluation and treatment of intractable pain when it is determined to be medically necessary and otherwise eligible by Aetna. Intractable pain means "a pain state in which the cause of the pain cannot be removed or otherwise treated and which, in the generally accepted practice of allopathic or osteopathic medicine, no relief of the cause of the pain or cure of the cause of the pain is possible or none has been found after reasonable efforts, including, but not limited to, evaluation by the attending physician and by one or more other physicians specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain."

## 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 does not provide health care services and, therefore, cannot guarantee any results or outcomes. Consult the plan documents [Booklet, Booklet-certificate] 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. Some benefits are subject to limitations or visit maximums.

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