Important Disclosure Information

For Health Maintenance Organization (HMO) Plans

The following information forms part of the information you will find in the Aetna Health Inc. Individual Advantage Subscriber Contract.

General information

Your plan of benefits is underwritten by Aetna Health Inc. 333 Earle Ovington Boulevard, Suite 104, Uniondale, New York, 11553. You may contact us at this address or by contacting our Member Services Unit at 1-888-982-3892.

Member Services and the Aetna Navigator® Member website

When you require assistance from an Aetna representative, call us during regular business hours at the number on your ID card or email us at **www.aetna.com**. You may also access your plan information from our secure member website at Aetna Navigator.

To access Aetna Navigator, Click on "Log In," enter your user name and password and click "Secure Log In." If you are not a **Member** yet, click on "Register Now" or click "Take a Tour" to learn more.

Aetna Navigator allows you to:

- Check a claim payment.
- Compare **Hospitals** in your area or anywhere in the country.
- Obtain medical costs and prescription prices.
- Obtain healthy lifestyle information.
- Obtain health information from Harvard Medical School.
- Look through our online encyclopedia for information about hundreds of health conditions.

For online member services, Click on "Contact Us" after you log on. Our representatives can:

- Verify or change personal information about your coverage
- Answer benefits questions
- Help you locate network **Providers**
- Find care outside your area
- Advise you how to file a claim or check on a claim payment
- 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

Interpreter services

Aetna provides a multilingual hotline with interpreters. Call the Multilingual hotline at 1-888-982-3862 (140 languages are available). You must ask for an interpreter.

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

Si usted necesita este documento en otro idioma, por favor llame a Servicios al Miembro al 1-888-982-3862.

Aetna provides information in many languages. **If you need this material translated into another language, please call Member Services at 1-888-982-3862.**

Hearing impaired

Aetna provides a special toll-free contact number for the hearing impaired. TDD 1-800-628-3323

Plan of benefits

Covered services include most types of treatment provided by **Primary Care Physicians**, **Specialists** and **Hospitals**. However, the health plan does exclude and/or include limits on coverage for some services. In addition, in order to be covered, all services, including the location (type of facility), duration and costs of services, must be **Medically Necessary** as defined below and as determined by Aetna. The information that follows provides general information regarding Aetna health plans. For a complete description of the benefits available to you, including procedures, exclusions and limitations, refer to your specific plan documents, which may include the Subscriber Contract and any applicable riders and amendments to your plan.

Aetna®

General conditions for coverage

The service or supply must be covered by the plan. For a service or supply to be covered, it must: be included as a covered expense in your plan documents and not be an excluded expense and not exceed the maximums and limitations outlined in your plan documents; and be obtained in accordance with all the terms, policies and procedures outlined in your plan documents. The plan will pay for covered medical expenses, up to the maximums shown in your Subscriber Contract. You are responsible for any expenses incurred over the maximum limits or any noncovered health care procedures treatments or services as outlined in your Subscriber Contract.

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.

Important Note
Not every service, supply or prescription drug that fits the definition for medical necessity is covered by the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. For example, some benefits are limited to a certain number of days, visits or a dollar maximum. Refer to your *What the Plan Covers and the Summary of Benefits* for the plan limits and maximums.

Accessing Network Health Care Providers with a Referral

To access network benefits, you are required to select a **Primary Care Physician** (**PCP**) when you enroll. A **PCP** may be a general practitioner, family **Physician**, internist, or a pediatrician. Each covered family **Member** may select his or her own **PCP**. Your **PCP** provides routine preventive care and will treat you for illness or injury. Your **PCP** may refer you to network **Providers** or facilities such as **Specialists** and **Hospitals** for other covered services and supplies. The **PCP** can also order lab tests and X-rays, prescribe medicines or therapies and arrange hospitalization. Except in a **Medical Emergency** or for certain direct access **Specialist** benefits as described in your Subscriber Contract, only those services which are provided by or referred by your **PCP** will be covered as a network benefit.

Member cost sharing

You are responsible for any **Copayments**, coinsurance and deductibles for covered services. **Copayments** obligations are paid directly to the **Provider** or facility at the time the service is rendered. Coinsurance and deductible obligations are paid to the **Provider** or facility once your claim has been processed and you have received an Explanation of Benefits from Aetna. **Copayment**, coinsurance and deductible amounts are listed in your Plan Documents.

Role of Primary Care Physicians ("PCPs")

You are required to select a **PCP** who participates in the network. If you do not select one, we will assign you a **PCP** in your area, based on your zip code. If you wish to choose a different **PCP**, you may do so at anytime. To find a new doctor in your area, call Member Services at the toll-free number on your member ID card, or visit DocFind®, our online **Provider** directory at **www.aetna.com**. Through **www.aetna.com** you can also register for our Aetna Navigator® self-service website and select the "Change PCP" option. Before selecting a **PCP,** you should either call Member Services at the number on your ID card or call the doctor's office directly to verify that he/she is accepting new patients.

A **PCP** may be a general practitioner, family **Physician**, internist, or a pediatrician. Each covered family Member may select his or her own **PCP**. Your **PCP** will provide primary care as well as coordinate your overall care. You should consult your **PCP** when you are sick or injured to help determine the care that is needed. Your **PCP** will issue **Referrals** to **Participating Specialists** and facilities for certain services. For some services, your **PCP** is required to obtain prior authorization from Aetna. Except for those benefits described in the plan documents as direct access

benefits, or in an emergency, you will need to obtain a **Referral** authorization ("**Referral**") from your **PCP** before seeking covered non-emergency specialty or **Hospital** care.

Find a doctor

You can search Aetna's online directory DocFind by logging on to Aetna's website at **www.aetna.com**. You can search DocFind for names and locations of **Physicians** and other health care **Providers** and facilities. You can look for a doctor by specialty and location. All the information is here, plus maps and directions to the doctor's office. You can even look for doctors who are board certified, speak your language, and who are accepting new patients. The online directory is updated weekly and contains the most current list of network **Providers**.

If you need a printed directory, call Member Services at the toll-free number on your ID card. If you are not an Aetna **Member** yet, or if you have not received your ID card call 1-888-87-AETNA (1-888-872-3862). If you use the printed directory, you should call Member Services or the **Provider** to verify the **Provider** is accepting new patients. Your employer also has copies of **Provider** directories for your reference.

Aetna cannot guarantee the availability or continued participation of a particular **Provider**. Either Aetna or any network **Provider** may terminate the **Provider** contract or limit the number of people accepted in a practice. If the **Physician** initially selected cannot accept additional patients, you will be notified and given an opportunity to make another selection.

How to change your PCP or Specialist

You may change your **PCP** or **Specialist** at any time on Aetna's website, **www.aetna.com**, or by calling the Member Services toll-free number on your identification card. The change will become effective upon Aetna's receipt and approval of the request.

How Referrals work

Except for **PCPs**, direct access and emergency or **Urgent Care** services, you must have a prior written or electronic **Referral** from your **PCP** to receive the plan's network level of coverage for all services and any necessary follow-up treatment. The **Referral** will be good for 90 days, as long as you remain covered under the plan.

- When you visit the **Provider** or facility, bring the **Referral** (or check in advance to verify that they've received the electronic **Referral**). Without it, you'll receive out-of-network coverage — even if you receive your treatment from a network **Provider**.
- Certain services such as inpatient stays, outpatient surgery and certain other medical procedures and tests require both a **PCP Referral** *and* precertification. Precertification verifies that the recommended treatment is covered by Aetna. Your **PCP** or other network **Providers** are responsible for obtaining precertification for you for in-network services.

Out-of-Network Referrals for HMO plans

If a service you need isn't available from a network **Provider** or facility, your **PCP** may refer you to an out-of-network **Provider**. Your **PCP** or other network **Provider** must get pre-approval from Aetna and issue a special non-participating **Referral** for services from out-of-network **Providers** to be covered at the network level of benefits.

Standing Referrals

If you have a condition which requires ongoing care from a **Specialist**, you may request a standing **Referral** from your **PCP** or Aetna to such a **Specialist**.

Specialist as PCP

If you have a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, you may request a **Referral** to a **Specialist** with expertise in treating the life-threatening or degenerative and disabling disease or condition who shall be responsible for and capable of providing and coordinating your primary and specialty care. This **Referral** will be issued based on a treatment plan that is approved by Aetna, in consultation with the primary care **Provider** if appropriate, the **Specialist**, and you or your authorized representative.

Direct Specialist care for life threatening conditions

If you have a life-threatening condition or disease or a degenerative and disabling condition or disease either of which requires specialized medical care over a prolonged period of time, you may request access to a specialty care center, or a **Specialist** responsible for providing or coordinating your medical care. In order to request these services, please call Member Services at the toll-free number on your ID card or call 1-888-982-3862.

You don't need a PCP Referral for:

- Emergency care – See In Case of **Medical Emergency**.
- **Urgent Care** – See Care for Urgent Medical Conditions.

- Direct access services – services from network **Providers** for which the **Referral** is not required. Certain routine and preventive services do not require a **Referral** under the plan when accessed in accordance with the age and frequency limitations outlined in the "What the Plan Covers" and the "Summary of Benefits" sections of your plan documents. Refer to the "What the Plan Covers" section for information on when these benefits are covered. You can directly access these network **Specialists** for:
  - Routine gynecologist visits
  - Routine eye exams in accordance with the schedule
  - Annual screening mammogram for age-eligible women
  - Routine Prenatal Care (precertification may be required)

Direct access Ob/Gyn program
This program allows female **Members** to visit any **Participating** obstetrician or gynecologist for a routine well-woman exam, including a Pap smear, and for obstetric or gynecologic problems. Obstetricians and gynecologists may also refer a woman directly to other **Participating Providers** for covered obstetric or gynecologic services. All health plan preauthorization and coordination requirements continue to apply. If your Ob/Gyn is part of an Independent Practice Association (IPA), a Physician Medical Group (PMG), an Integrated Delivery System (IDS) or a similar organization, your care must be coordinated through the IPA, the PMG or similar organization and the organization may have different **Referral** policies.

Transition of care

If a **Participating Provider** leaves the Aetna network, **Members** who are under an ongoing course of treatment on the day the **Provider's** agreement terminates may continue to receive treatment from the **Provider** during a transitional period of up to ninety days. Female **Members** who have entered the second trimester of pregnancy may continue to receive treatment from the **Provider** for a transitional period that includes the provision of post-partum care directly related to the delivery.

A **Member** whose health care **Provider** is not a **Participating Provider** at the time of enrollment may request to continue an ongoing course of treatment with that **Provider** for a period of up to 60 days from the effective date of enrollment if the **Member** has a life-threatening disease or condition or a degenerative and disabling disease or condition. If the **Member** has entered the second trimester of pregnancy at the effective date of enrollment, the transitional period shall include post-partum care directly related to the delivery.

For such a request for transitional coverage to be approved, the health care **Provider** must agree to accept reimbursement from Aetna at established rates prior to the start of the transitional period as payment in full; adhere to Aetna's quality assurance requirements; provide Aetna with necessary medical information related to this care; and adhere to Aetna's policies and procedures.

In accordance with New York law, transitional care is not permitted if the **Provider** leaves the network due to imminent harm to patient care, a determination of fraud or a final disciplinary action by a state licensing board (or other governmental agency) that impairs the health care professional's ability to practice.

Transplants and other complex conditions

Our National Medical Excellence Program® and other specialty programs help you 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, you 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 means a medical or behavioral condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy; or (2) serious impairment of such person's bodily functions; or (3) serious dysfunction of any bodily organ or part of such person; or (4) serious disfigurement of such person.

Treatment for an emergency medical condition is not subject to prior approval. However, 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 as soon as possible.
- Covered expenses for emergency medical conditions are payable in accordance with your plan. Please refer to your Summary of Benefits for the applicable copay, deductible and coinsurance amounts that apply.

What to do outside your Aetna Service Area
If you are traveling outside your Aetna **Service Area** or if you are a student who is away at school, you are covered for emergency and urgently needed care. **Urgent Care** may be obtained from a private practice **Physician**, a walk-in clinic, an **Urgent Care** center or a hospital emergency room. Certain conditions, such as severe vomiting, earaches, sore throats or fever, are considered "**Urgent Care**" outside your Aetna **Service Area** and are covered in any of the above settings.

Claims for emergency care
If, after reviewing information submitted to us by the **Provider** that supplied care, the nature of the emergency problem does not qualify for coverage, it may be necessary to provide us with additional information. We will send you an Emergency Room Notification Report to complete, or a Member Services representative can take this information by telephone. However, expenses that are not related to an emergency medical condition are excluded and are the **Member's** financial responsibility.

Follow-up care after emergencies
All follow-up care should be coordinated by your **PCP**. Follow-up care with nonparticipating **Providers** is only covered with a **Referral** from your **PCP** and prior authorization from Aetna. Whether you were treated inside or outside your Aetna **Service Area**, you must obtain a **Referral** before any follow-up care can be covered. Suture removal, cast removal, X-rays and clinic and emergency room revisits are some examples of follow-up care.

After-hours care
You may call your doctor's office 24 hours a day, 7 days a week if you have medical questions or concerns. You may also consider visiting **Participating Urgent Care** facilities.

How Aetna compensates your health care Provider and other Providers

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

Participating 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)
- Capitation (a prepaid amount per **Member**, per month)
- Through Integrated Delivery Systems (IDS), Independent Practice Associations (IPA), Physician Hospital Organizations (PHO), Physician Medical Groups (PMG), behavioral health organizations and similar **Provider** organizations or groups. Aetna pays these organizations, which in turn may reimburse the **Physician**, **Provider** organization or facility directly or indirectly for covered services. In such arrangements, the group or organization has a financial incentive to control the cost of care

Technology review

Aetna reviews new medical technologies, behavioral health procedures, pharmaceuticals and devices to determine which one should be covered by our plans. And we even look at new uses for existing technologies to see if they have potential. To review these innovations, we may:

- Study 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.

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 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 basis or a deductible, your costs may be higher for a preferred drug than they would be for a nonpreferred drug.

Closed formulary benefits plans may use a formulary exclusions list. Under these benefits plans, a drug on this list will be excluded from coverage unless a medical exception is obtained. In addition, some benefits plans may include Aetna's precertification or step-therapy programs. Under the step-therapy program, **Members** must first try certain prerequisite medication(s) before a step-therapy drug will be covered.

The prescribing **Physician** can submit a request for a medical exception to Aetna Pharmacy Management's Precertification Unit in writing, by phone, or online. Information provided must include **Member** identification, medical history, and laboratory data necessary to review the request.

The request for medical exception will be reviewed along with the Aetna Pharmacy Clinical Policy Bulletin applicable to the medication. If the medical exception meets the criteria established in the clinical policy bulletin, Aetna will notify the **Physician** and **Member** of the authorization. If an Aetna medical director determines the drug is not approved for coverage, an adverse determination letter will be sent to the **Member** and **Provider**. The notice will explain the reason for the denial of coverage and the appeal process.

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 ID card. The medications listed on the preferred drug list are subject to change in accordance with applicable state law.

Your prescription drug benefits are 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 benefits plans. Some prescription drug benefits 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** (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 benefits 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 you to use a medication subject to these requirements, your **Physician** can request coverage of such drug as a medical exception.

You may determine which medications are included in the Step Therapy Program and require trial of prerequisite drugs through any of the following methods:

- Contacting Member Services via the phone number on your ID card
- Via the public website **www.aetna.com/formulary**
- Via the "Medication Search" application on the website above
- Accessing **Member** specific coverage information via Aetna's secure member website — Aetna Navigator

In addition, some benefits 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.

You should consult with your treating **Physician(s)** 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., or the Aetna Specialty Pharmacy® specialty drug program, you will be acquiring these prescriptions through an affiliate of Aetna. Aetna's negotiated charge with Aetna Rx Home Delivery® and Aetna Specialty Pharmacy may be higher than their cost of purchasing drugs and providing pharmacy services. For these purposes, Aetna Rx Home Delivery's and Aetna Specialty Pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

Updates to the drug formulary
You can obtain formulary information from the Internet at **www.aetna.com/formulary**, or by calling your Member Services toll-free number.

Behavioral health network

Behavioral health care services are managed by Aetna, who is responsible for making initial coverage determinations and coordinating **Referrals** to Aetna's **Provider** network. As with other coverage determinations, you may appeal adverse behavioral health care coverage determinations in accordance with the terms of your health plan.

The type of behavioral health benefits available to you depends upon the terms of your health plan. If your health plan includes behavioral health services, you may be covered for mental health conditions and/or drug and alcohol abuse services, including inpatient and outpatient services, **Partial Hospitalizations** and other behavioral health services. You can determine the type of behavioral health coverage available under the terms of your plan and how to access services by calling the Aetna Member Services number listed on your ID card.

If your health plan includes behavioral health services, you may be covered for mental health conditions and/or drug and alcohol abuse services. You can determine the type of behavioral health coverage available under the terms of your plan by calling the Aetna Member Services number listed on your ID card. If you have an emergency, call 911 or your local emergency hotline, if available. For routine services, access covered behavioral health services available under your health plan by the following methods:

Call the toll-free Behavioral Health number (where applicable) listed on your ID card or if no number is listed, call the Member Services number listed on your ID card for the appropriate information.

Where required by your plan, call your **PCP** for a **Referral** to the designated **Behavioral Health Provider** group. When applicable, an employee assistance or student assistance professional may refer you to your designated **Behavioral Health Provider** group.

You can access most outpatient therapy services without a **Referral** or pre-authorization. However, you should **first** consult with Member Services to confirm that any such outpatient therapy services do not require a **Referral** or pre-authorization.

Behavioral Health Provider safety data available
For information regarding our **Behavioral Health Provider** network safety data, please go to **www.aetna.com** and review the quality and patient safety links posted: **www.aetna.com/docfind/quality.html#jcaho**. You may select the quality checks link for details regarding our **Providers'** safety reports.

Behavioral health 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® Maternity Program and Identification and Referral of Adolescent Members Diagnosed With Depression Who Also Have Co-morbid 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.

Clinical Policy Bulletins (CPBs)

Aetna's CPBs describe Aetna's policy determinations of whether certain services or supplies are **Medically Necessary** or experimental or investigational, 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 for your treatment. You should discuss any CPB related to your coverage or condition with your 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. 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's CPBs are available online at **www.aetna.com**.

Precertification

Precertification is the process of collecting information prior to inpatient admissions and performance of selected ambulatory procedures and services. The process permits advance eligibility verification, determination of coverage, and communication with the **Physician** and/or you. It also allows Aetna to coordinate your transition from the inpatient setting to the next level of care (discharge planning), or to register you for specialized programs like disease management, case management, or maternity management programs. In some instances, precertification is used to inform **Physicians**, **Members** and other health care **Providers** about cost-effective programs and alternative therapies and treatments.

Certain health care services, such as hospitalization or outpatient surgery, require precertification with Aetna. When you are to obtain services requiring precertification from a **Participating Provider**, the **Provider** is responsible to precertify those services prior to treatment. If you self refer for **Covered Benefits**, it is your responsibility to contact Aetna to precertify those services which require precertification to avoid a reduction in benefits paid for that service.

Utilization review

"Utilization review" means the review to determine whether health care services that have been provided, are being provided or are proposed to be provided are **Medically Necessary** or are **Experimental or Investigational Procedures**. An "adverse determination" means a utilization review determination that an admission, extension of stay, or other health care services, is not **Medically Necessary**.

To contact the Utilization Review Agent, call Member Services at the toll-free number on your ID card or call 1-888-982-3862. 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. The Utilization Review Agent is available during regular business hours (8 a.m. – 4 p.m. ET), Monday though Friday. For calls made after business hours or during the weekend, the **Member** can leave a message.

Whether a utilization review determination is made before, during or after services are provided, any adverse determination, including a claim denial, will be made by a clinical peer reviewer and all notices of adverse determinations will include the specific reasons for the denial as well as information about your rights to appeal, including your right to appeal a final adverse determination to the New York State External Review Program. *All final adverse determinations will be made by a clinical peer reviewer other than the clinical peer reviewer who made the initial adverse determination.*

Preservice claims

Preservice claims review is the review for approval of a claim before the service has taken place.

Aetna will make notification of a claim determination as soon as possible but not later than 3 business days after receipt of the claim. In the event the **Member** fails to provide all of the necessary information for Aetna to make a claim determination, Aetna will request such information within 3 days of receipt of the claim and will allow the **Member** 45 days to submit the necessary information. Aetna will make a claim determination within 3 business days after receipt of such information. If the information requested is not received by Aetna after 45 days, Aetna will make a determination based on information available and will notify the **Member** of the decision within 15 days. Aetna will notify the **Member**, or the **Member's** designee, and the **Member's** health care **Provider** of the determination by telephone and in writing. Notification will include the total of approved services, the date of the onset of services and the next review date.

With respect to preservice **Urgent Care** claims, Aetna will make a notification by telephone and in writing within 72 hours after receipt of the claim. If more information is needed, Aetna will request it within 24 hours. The **Member**, the **Member's** designee and the Member's health care **Provider** will have 48 hours to submit the needed information. Aetna will make a determination and provide notice to you or your designee and your health care **Provider** by telephone and in writing within 48 hours of the earlier of Aetna's receipt of the information or the end of the 48-hour period after Aetna's request of the information.

Concurrent care claim extension

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.

Following a request for a concurrent care claim extension, Aetna will make notification of a claim determination by telephone and in writing to the **Member**, the **Member's** designee and the **Member's** health care **Provider** as soon as possible, but no later than one day after receipt of the necessary information, or 15 days from receipt of the claim.

With respect to home health care services following an inpatient **Hospital** admission, Aetna will make the notification no later than 72 hours after receipt of the necessary information when the day subsequent to the request falls on a weekend or a holiday. But, coverage shall not be denied on the basis of medical necessity or lack of authorization while the decision is pending.

With respect to concurrent claims that involve urgent matters, Aetna will make a determination and will notify the **Member**, the **Member's** designee and the **Member's** health care **Provider** by telephone and in writing within 24 hours after receipt of the request, if the request for additional information is made at least 24 hours prior to the end of the period for which benefits have been approved. Requests that are not made within this time will be determined within the timeframes for preservice **Urgent Care** claims. If Aetna has approved a course of treatment, Aetna will not reduce or terminate the approved services before giving the **Member** enough prior notice of the reduction or termination so that the

Member can complete the appeal process before the services are reduced or terminated.

Postservice claims
The purpose of postservice claim review is to review initial requests for certification received after discharge or after the provision of services, retrospectively analyze potential quality and utilization issues, initiate appropriate follow-up action based on quality or utilization issues, and review all appeals of inpatient concurrent review decisions for coverage of 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.

Aetna will make notification of a claim determination in writing as soon as possible but not later than 30 calendar days after receipt of the claim. In the event the **Member** fails to provide all of the necessary information for Aetna to make a claim determination, Aetna will allow the **Member** 45 days to submit the necessary information, and will make a claim determination within 15 days after receipt of such information. If the information requested is not received by Aetna after 45 days, Aetna will make a determination based on information available and will notify the **Member** of the decision within 15 days.

The notice of adverse determination will include:

- The reasons for the adverse determination, including reference to specific plan provisions upon which the determination is based and the clinical rationale, if any
- A description of Aetna's review procedures, including a statement of claimants' rights to bring a civil action
- Instructions how to start the appeals, expedited appeals and external appeals process
- Notice of the availability, upon request, of the clinical review criteria used to make the adverse determination. This notice will also specify what necessary additional information, if any, must be provided to, or obtained by, Aetna in order to render a decision on appeal.

In the event that Aetna renders an adverse determination without first attempting to discuss the matter with the **Member's** health care **Provider** who specifically recommended the service, the health care **Provider** will have the opportunity to request a reconsideration of the adverse determination. Except for postservice claims, such reconsideration will occur within one business day of receipt by Aetna of the request. If the adverse determination is upheld, Aetna will provide notice, as described above.

If Aetna does not render a decision within the period set forth above, the **Member** may consider this to be an adverse determination, subject to appeal.

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 for the **Member** after s/he is released from the inpatient facility.

Reconsideration review
In the event that an adverse determination is made without attempting to discuss the matter with your health care **Provider** who recommended the health care service, procedure or treatment under review, the **Provider** has an opportunity to request reconsideration through discussion with the clinical peer reviewer. Reconsideration shall occur in one business day of the receipt of the request. Reconsideration does not apply to retrospective reviews.

We may reverse a preauthorized treatment service or procedure retrospectively: (1) when the relevant medical information presented to us is materially different from the information presented during the original preauthorization; (2) when the relevant medical information presented to us upon the retrospective review existed at the time of preauthorization but was withheld from or not made available to us; and (3) we were not aware of the existence of the information at the time of the preauthorization review; and (4) if we had been aware of this information, the treatment service or procedure being requested would not have been authorized. The determination is to be made using the same specific standards, criteria or procedures as used during the preauthorization review.

You have the right to designate a representative to act on your behalf, or to have any person who has legal responsibility to make medical care decisions for you.

All clinical denials will be made by a clinical peer reviewer and all denial notices will contain information about the basis for the decision.

Appeals procedure

Definitions
Adverse Determination: A denial; reduction; termination of; or failure to provide (in whole or in part) a service because it is determined to be an **Experimental or Investigational Procedure** or not **Medically Necessary** or appropriate.

Such an **Adverse Determination** may be based on, among other things:

A **Member's** eligibility for coverage;

Plan limitations or exclusions;

The results of any Utilization Review activities (determination as to whether or not an admission, extension of stay, or other health care service or supply is **Medically Necessary**, based on the information provided).

Denials of out-of-network claims on the basis that a service is not materially different than an alternate service available under the **Contract** shall not constitute an **Adverse Determination**.

Appeal: An oral or written request to Aetna to reconsider an **Adverse Determination**.

Complaint: Any oral or written expression of dissatisfaction about quality of care or the operation of the plan.

Concurrent Care Claim Extension: A request to extend a previously approved course of treatment or provide additional services or home health care services following discharge from an inpatient **Hospital** admission.

Expedited Appeal: Appeal of an **Adverse Determination** involving (1) continued or extended services, procedures and treatments or additional services for a **Member** undergoing a course of continued treatment prescribed by a **Health Care Provider**, or home health care or rehabilitation facility services following discharge from an inpatient **Hospital** admission or (2) an **Adverse Determination** in which the **Health Care Provider** believes an immediate **Appeal** is warranted where there is imminent or serious threat to the health of the **Member**, except any retrospective determination, or (3) for an **Adverse Determination** involving an **Urgent Care** claim. Aetna will provide reasonable access by the **Health Care Provider** to the clinical peer reviewer within one business day of receipt of the appeal.

Grievance: A request for review of a determination, other than (a) a determination meeting the definition of **Adverse Determination**, and (b) a **complaint**.

Health Care Provider: A health care professional or a facility licensed pursuant to New York law.

Preservice Claim: Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

Postservice Claim: Any claim that is not a "**Concurrent Care Claim Extension**," an "**Urgent Care Claim**" or a "**Preservice Claim**."

Out-of-Network Denial: A denial of a request for preauthorization to receive a health service from an out-of-network provider on the basis that such service is not materially different from a service available under the **Contract**. The notice of denial of such service shall include information explaining what information must be submitted to **Appeal** the denial.

Rare Disease: A life threatening or disabling condition or disease that: (1)(a) is currently or has been subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network; or (b) affects fewer than 200,000 United States residents per year; and (2) for which there does not exist a standard health service or procedure covered by the plan that is more clinically beneficial than the requested health service or treatment.

Urgent Care Claim: Any claim for medical care or treatment with respect to which a delay: (a) could seriously jeopardize the life or health of the **Member** or the ability of the **Member** to regain maximum function; or (b) in the opinion of a **Physician** with knowledge of the **Member's** medical condition would subject the **Member** to severe pain that cannot be adequately managed without the requested treatment.

Complaints

If the **Member** is dissatisfied with the service he or she receives from Aetna or wants to complain about a health care **Provider**, the **Member** must call or write Member Services. The **Member** must include a detailed description of the matter and include copies of any records or documents that the **Member** thinks are relevant to the matter. Aetna will review the information and provide the **Member** with a written response within 15 calendar days of the receipt of the complaint, unless additional information is needed and cannot be obtained within this period. The notice of the decision will tell the **Member** what he or she needs to do to seek an additional review.

The Member Services telephone number is on the **Member's** ID card. If **Member** is required to leave a recorded message, the message will be acknowledged within one business day after the call was recorded.

Appeals of out-of-network benefit denials

The **Member** may appeal a denial of out-of-network benefits based on the fact that an alternate service is available under the **Contract** by submitting:

- A written statement from the **Member's Physician** that the service is materially different from the health service approved to treat the **Member's** medical needs under the **Contract**
- Two documents from available medical and scientific evidence, stating that the out-of-network service is likely to be more clinically beneficial than the alternate service under the **Contract**, and the adverse risk would not be substantially increased

Appeals of Adverse Determinations

The **Member** may submit an appeal if Aetna gives notice of an adverse determination. It will also provide an option to request an external review of the adverse determination.

The **Member** has 180 calendar days following the receipt of notice of an adverse determination to request the appeal. The Notice will be sent to the **Member**, the **Member's** designee and the **Member's** health care **Provider**. The appeal may be submitted orally or in writing. The request should include:

The **Member's** name

A statement from the **Member's** health care **Provider**

A copy of Aetna's notice of an adverse determination

The **Member's** reasons for making the appeal

Any other information the **Member** would like to have considered

The **Member** should send the appeal to Member Services at the address shown on the **Member's** ID Card, or call in the appeal to Member Services, using the toll-free telephone number shown on the ID Card.

The **Member** may also choose to have an authorized designee make the appeal on his or her behalf by providing written consent to Aetna. The **Member's** health care **Provider** may make the appeal in connection with the adverse determination for a postservice claim.

Appeal

The appeal of an adverse determination shall be decided by Aetna personnel not involved in making the adverse determination. Aetna will acknowledge receipt of the appeal (other than an expedited appeal) within 15 days of its receipt.

Expedited appeals

Aetna has established an expedited appeals process for adverse determinations involving **Urgent Care** claims, concurrent care claim extensions and preservice claims. Aetna will render a decision involving **Urgent Care**, concurrent claim extension and preservice claims within the earlier of 72 hours of receipt of the appeal or 2 business days from receipt of the necessary information to conduct the appeal. Expedited appeals that do not result in a resolution to the **Member's** satisfaction may be further appealed through the external appeals process.

Preservice claims (other than those subject to an expedited appeal)

Aetna shall issue a decision within 15 days of receipt of the appeal.

Postservice claims

Aetna shall issue a decision within the earlier of 15 days of receipt of the necessary information to conduct the appeal or 60 days of receipt of the request for an appeal.

The notice of the appeal determination will include:

- If the adverse determination is upheld, the reason for the determination, including the clinical rationale for it; and

A notice of the **Member's** right to an external appeal, together with information and a description of the external appeals process.

If Aetna does not render an appeal determination for a standard or expedited appeal within the timeframes set forth above, the adverse determination will be reversed.

*At any time during the complaints process, the **Member** has the right to contact the New York State Department of Health at 1-800-206-8125, or by mail at New York State Department of Health, Division of Managed Care, Bureau of Managed Care Certification and Surveillance, Empire State Plaza, Corning Tower, Room 1911, Albany, New York 12237-0062.*

Grievances

The **Member** may submit a grievance, orally (by calling the toll-free telephone number shown on the ID Card) or in writing, to Aetna with respect to review of any determination other than an adverse determination. The grievance must be submitted within 180 days after receipt of the notice of the determination.

Aetna will acknowledge receipt of the grievance in writing within 15 calendar days after its receipt by Aetna. The acknowledgment will include the name, address and telephone number of the person or department designated by Aetna to respond to the grievance.

A grievance may be submitted if coverage is being rescinded pursuant to B. 3. of the "Termination of Coverage" section of the Contract. In that case, Aetna will continue the **Member's** coverage until a final decision on the grievance is rendered, provided the premium is paid through the period prior to the issuance of such final decision. Aetna may rescind coverage, to the date coverage would have terminated had the **Member** not submitted the grievance to Aetna, if the final decision is in favor of Aetna. If coverage is rescinded, Aetna will provide the **Member** with a 30 day advance written notice prior to the date of the rescission, and refund any premiums paid for any period after the termination date, minus the cost of Covered Benefits provided to the **Member** during this period.

The grievance process for rescissions described above applies only to those terminations affected pursuant to the "Termination of Coverage" subsection of the Contract.

Grievance determinations

Expedited grievances

Aetna will resolve an expedited grievance within the lesser of 48 hours from receipt of the necessary information or 72 hours from receipt of the grievance when delay would significantly increase the risk to a **Member's** health.

Standard grievances
For other grievances, Aetna will resolve the grievance within the lesser of 30 days from receipt of the necessary information or 15 days from receipt of the grievance for preservice claims grievances, or 30 days after receipt of a postservice claims grievance.

Grievance appeals
Aetna will acknowledge receipt of the grievance appeal within 15 days of its receipt. The acknowledgment will include the name, address and telephone number of the person or department designated by Aetna to respond to the grievance appeal, and will indicate any additional information needed to review the appeal. The determination of an appeal on a clinical matter will be made by qualified clinical personnel, including a clinical peers reviewer, who did not make the initial determination. A non-clinical appeal determination will be made by qualified personnel at a higher level than the personnel who made the grievance determination.

Expedited grievance appeals
Aetna will render a decision within 36 hours after receipt of the appeal.

Standard grievance appeals
For other grievances, Aetna will render a decision within 15 days from receipt of the grievance appeal for preservice claims grievances and within 30 days from receipt of the grievance appeal for postservice claims grievances.

External review
Right to an external appeal
Under certain circumstances, the **Member** has a right to an external appeal of a denial of coverage. Specifically, if Aetna has denied coverage on the basis that the (a) service is not **Medically Necessary** or is an **Experimental or Investigational Procedure** or (b) such service is provided out-of-network and an alternate is available under the **Contract**, the **Member** may appeal that decision to an external appeal agent (an independent entity certified by the state to conduct such appeals).

Right to appeal a determination that a service is not Medically Necessary
If the Aetna has denied coverage on the basis that the service is not **Medically Necessary**, the **Member** may appeal to an external appeal agent if the **Member** satisfies the following criteria listed below:

- The service must otherwise be a **Covered Service** under this **Contract**; and
- The **Member** must have received a final adverse determination through Aetna's internal review process and Aetna must have upheld the denial, or the **Member** and Aetna must agree in writing to waive any internal appeal.

Right to appeal a determination that a service is experimental or investigational
If a **Member** has been denied coverage on the basis that the service is an **Experimental or Investigational Procedure**, the **Member** must satisfy the following criteria:

- The service must otherwise be a **Covered Service** under this **Contract**; and
- The **Member** must have received a final adverse determination through Aetna's internal appeal process and Aetna must have upheld the denial, or the **Member** and Aetna must agree in writing to waive any internal appeal.

In addition, the **Member's** attending **Physician** must certify that the **Member** has a condition or disease for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered under this **Contract** or one for which there exists a clinical trial (as defined by law) or rare disease treatment. In the case of a rare disease, the attending **Physician** may not be the treating **Physician**.

The **Member's** attending **Physician** must be a licensed, board certified or board eligible **Physician** qualified to practice in the area of practice appropriate to treat the **Member's** condition. In the case of a rare disease, the attending **Physician** may not be the treating **Physician**.

In addition, the **Member's** attending **Physician** must have recommended at least one of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to the **Member** than any standard **Covered Service** (only certain documents will be considered in support of this recommendation. The **Member's** attending **Physician** should contact the state in order to obtain current information as to what documents will be considered acceptable); or in the case of a rare disease, based on the **Physician's** certification and such other evidence as the **Member**, the **Member's** designee or the **Member's** attending **Physician** may present; or
- A clinical trial for which the **Member** is eligible (only certain clinical trials can be considered).

Right to appeal a determination that an alternate service is available under the Contract.
If coverage for an out-of-network service (other than a clinical trial, which is covered immediately above), has been denied on appeal on the basis that an alternate service is available under the **Contract**, the **Member** may appeal to an external appeal agent if **Member** satisfies the following criteria listed below:

- The service, procedure or treatment must otherwise be a **Covered Service** under the plan.
- **Member** must have received a final adverse determination through Aetna's internal review process and Aetna must have upheld the denial, or the **Member** and Aetna must agree in writing to waive any internal appeal.
- The attending **Physician** certifies that such out-of-network service is (i) materially different than the alternate service under the **Contract**; and (ii) based on two documents from available medical and scientific evidence, such service is likely to be more clinically beneficial than the alternate service under the **Contract** and the adverse risk would not be substantially increased.

For the purposes of this section, the **Member's** attending **Physician** must be a licensed, board certified or board eligible **Physician** qualified to practice in the area appropriate to treat the **Member's** condition or disease, or rare disease. In the case of a rare disease, the attending **Physician** may not be the treating **Physician**.

The external appeal process
If, through Aetna's internal appeal process, the **Member** has received a final adverse determination upholding a denial of coverage on the basis that the service is not **Medically Necessary** or is an **Experimental or Investigational Procedure**, or an alternate service is available out-of-network, the **Member** has four months from receipt of such notice to file a written request for an external appeal. If the **Member** does not file for an external appeal within four monthss, the **Member** will lose the right to the external appeal. If the **Member** and Aetna have agreed to waive any internal appeal, the **Member** has four months from the receipt of such waiver to file a written request for an external appeal. Aetna will provide an external appeal application with the final adverse determination issued through Aetna's internal appeal process or its written waiver of an internal appeal.

The **Member** may also request an external appeal application from the New York State Department of Financial Services by calling 1-800-400-8882 or at their website, **www.dfs.ny.gov**.

The **Member** shall submit the completed application to the New York State Department of Financial Services at the address listed in the application. If the **Member** satisfies the criteria for an external appeal, the state will forward the request to a certified external appeal agent. The **Member** will have the opportunity to submit additional documentation with the request. If the external appeal agent determines that the information the **Member** submits represents a material change from the information on which Aetna based its denial, the external appeal agent will share this information with Aetna in order for it to exercise its right to reconsider its decision. If Aetna chooses to exercise this right, Aetna will have three (3) business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), Aetna does not have a right to reconsider its decision.

Aetna will charge a $25.00 fee to **Members** or their designees, not to exceed $75.00 in a [calendar] year. The fee is waived for **Members** who appeal if the fee will pose a hardship. Aetna will charge health care providers a $50.00 fee per appeal. The fee will be returned if the external appeal agent overturns Aetna's denial.

In general, the external appeal agent must make a decision within thirty (30) days of receipt of the completed application. The external appeal agent may request additional information from the **Member**, the **Member's Physician** or health care **Provider** or Aetna. If the external appeal agent requests additional information, it will have five (5) additional business days to make its decision. The external appeal agent must notify the **Member** or the **Member's Physician**, where appropriate in writing of its decision within two (2) business days.

If the **Member's** attending **Physician** or health care **Provider** certifies that a delay in providing the service that has been denied poses an imminent or serious threat to the **Member's** health, the **Member** may request an expedited external appeal. In that case, the external appeal agent must make a decision within three (3) days of receipt of the completed application. Immediately after reaching a decision, the external appeal agent must try to notify the **Member** and Aetna by telephone or facsimile of that decision. The external appeal agent must also notify the **Member** in writing of its decision.

If the external appeal agent overturns Aetna's decision that a service is not **Medically Necessary** or approves coverage of an **Experimental or Investigational Procedure**, Aetna will provide coverage subject to the other terms and conditions of this **Contract**. If the external appeal agent approves coverage of an **Experimental or Investigational Procedure** that is part of a clinical trial, Aetna will only cover the costs of services required to provide treatment to the **Member** according to the design of the trial. Aetna shall not be responsible for the costs of investigational drugs or devices; the costs of non-health care services; the costs of managing research; or costs which would not be covered under this **Contract** for non-experimental or non-investigational procedures provided in such clinical trials.

The external appeal agent's decision is binding on both the **Member** and Aetna. The external appeal agent's decision is admissible in any court proceeding.

A **Physician** or health care **Provider** requesting an external appeal of an **adverse claim determination** involving a concurrent care claim, including when such **Physician** or health care **Provider** requests the external appeal as the **Member's** designee, shall not pursue reimbursement from any **Member** for services determined not **Medically Necessary** by the external appeals agent, except to collect a **Copayment**.

Member's responsibilities
Except as provided below under "Appeals of Admissions for or Provision or Continuation of Access to End of Life Care for Members Diagnosed with Advanced Cancer," it is the **Member's** responsibility to initiate the external appeals process. **Member** may initiate the external appeal process by filing a completed external appeal application with the New York State Department of Financial Services. The **Member** may designate an authorized representative at any time to pursue an external appeal. The **Member**, or the **Member's** designee, may file an external appeal application; but if it's filed by the **Member's** designee, the **Member** must consent to it in writing. The Department of Financial Services may request from the **Member** written confirmation of the appointment of a designee. In addition, the **Member's** attending **Physician** or health care **Provider** has the right to pursue an external appeal of a concurrent or a retrospective **adverse claim determination**. To do so, the attending **Physician** or health care **Provider** must complete an external appeal application for health care **Providers**. The **Member** must sign an acknowledgment of the request and consent to release any medical records.

Under New York State law, the completed request for appeal must be filed within four months of either: the date upon which the **Member** receives written notification from Aetna that it has upheld a denial of coverage; or the date upon which the **Member** receives a written waiver of any internal appeal. Aetna has no authority to grant an extension of this deadline.

Exhaustion of Process
Aetna encourages Members to exhaust the applicable processes of the internal appeal procedure before:

- Contacting the New York State Department of Financial Services to request an investigation of a [complaint or] appeal; or
- Filing a complaint or appeal with the New York State Department of Financial Services; or
- Establishing any:
  - litigation;
  - arbitration; or
  - administrative proceeding;

regarding an alleged breach of the policy terms by Aetna or any matter within the scope of the appeals procedure.

Covered services and exclusions
In general, the **Contract** does not cover **Experimental or Investigational Procedures**. However, the **Contract** shall cover an **Experimental or Investigational Procedure** approved by an external appeal agent in accordance with this section. If the external appeal agent approves coverage of an **Experimental or Investigational Procedure** that is part of a clinical trial, Aetna will only cover the costs of services required to provide treatment to you according to the design of the trial. Aetna shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this **Contract** for non-experimental or non-investigational procedures provided in such clinical trials.

Appeals of admissions for or provisions or continuation of access to end-of-life care for Members diagnosed with advanced cancer
The following applies if a **Member**: (i) has been diagnosed with advanced cancer (with no hope of reversal of primary disease and fewer than 60 days to live, as certified by the **Member's Physician**); and (ii) the **Physician**, in consultation with the medical director of a facility specializing in the treatment of terminally ill patients and licensed pursuant to Article 28 of the public health law, has determined that the **Member's** care would be appropriately provided by such facility.

In the event Aetna disagrees with the admission of or provision or continuation of care of the **Member** by the facility, Aetna must initiate an expedited external appeal as described above. However, until a decision is rendered, such admission for, provision of or continuation of the care by the facility will not be denied, and Aetna will continue to provide such coverage. The decision of the external appeals agent will be binding on all parties.

Aetna will keep records of the **Member's** complaint for seven years.

Member rights and responsibilities

Information

- Know the names and qualifications of the health care professionals involved in your medical treatment.
- Obtain complete and current information concerning a diagnosis, treatment and prognosis from a **Physician** or other **Provider** in terms you can be reasonably expected to understand. When it is not advisable for such information to be given to the **Member**, it shall be made available to an appropriate person on the **Member's** behalf.

- Get up-to-date information about the services covered or not covered by your plan and any applicable limitations or exclusions.
- Know how your plan decides what services are covered.
- Get information about **Copayments** and fees that you must pay.
- Get up-to-date information about the health care professionals, **Hospitals** and other **Providers** that participate in the plan.
- Be advised how to file a complaint, grievance or appeal with the plan.
- Know how the plan pays network health care professionals for providing services to you.
- Receive information from health care professionals about your medications, including what the medications are, how to take them and possible side effects.
- Receive from health care professionals as much information about any proposed treatment or procedure as you may need in order to give informed consent or refuse a course of treatment. Except in an emergency, this information should include a description of the proposed procedure or treatment, the potential risks and benefits involved, any alternate course of treatment (even if not covered) or nontreatment and the risks involved in each, and the name of the health care professionals who will carry out the procedure or treatment. When it is not advisable to give such information to you, your doctor may give such information to a person acting on your behalf.
- Be informed by **Participating Providers** about continuing health care requirements following discharge from inpatient or outpatient facilities.
- Be advised if a health care professional proposes to use an experimental treatment or procedure in your care. You have the right to refuse to participate in research projects.
- Receive an explanation regarding noncovered services.
- Receive a prompt reply when you ask questions about the plan or request information.
- Receive a copy of the plan's Member Rights and Responsibilities statement.

Access to care

- Obtain primary and preventive care from the **PCP** you chose from the plan's network.
- Change your **PCP** to another available **PCP** who participates in the plan.
- Obtain necessary care from **Participating** network **Specialists**, **Hospitals** and other **Providers**.
- Be referred to **Participating** network **Specialists** who are experienced in treating your chronic illness.
- Be advised by your health care professionals how to schedule appointments and get health care during and after office hours, including continuity of care.
- Be advised how to get in touch with your **PCP** or a backup **Physician** 24 hours a day, every day.
- Call 911 (or the local emergency hotline) or go to the nearest emergency facility when you have an emergency medical condition as defined in your plan documents.
- Receive urgently needed **Medically Necessary** care.

Freedom to make decisions

- Exercise these rights regardless of your race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion, national origin, cultural or educational background, economic or health status, English proficiency, reading skills or source of payment for your care.
- Have any person who has legal responsibility to make medical care decisions for you exercise these rights on your behalf.
- Refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.
- Complete an advance directive, living will or other directive and give it to your health care professionals.
- Know that you or your health care professionals cannot be penalized for filing a complaint or appeal.

Personal rights

- Be treated with respect for your privacy and dignity.
- Have your medical records kept private, except when permitted by law or with your approval.
- Help your health care professionals make decisions about your health care.

Input

- Have your health care professionals help you to make decisions about the need for services and with the complaint process.
- Suggest changes in the plan's policies and services. To submit suggestions on the plan's policies, please write to us at the address below:

  Aetna Health Inc.
  980 Jolly Road
  U12N, Blue Bell, PA 19422

Exercise your rights

- Choose a **PCP** from the plan's network and form an ongoing patient-**Physician** relationship.
- Help your health care professionals make decisions about your health care.

Follow instructions

- Read and understand your plan and benefits. Know the **Copayments** and what services are covered and what services are not covered.
- Follow the directions and advice on which you and your health care professionals have agreed.
- See the **Specialists** your **PCP** refers you to.
- Make sure you have the appropriate authorization for certain services, including **Referrals** and precertification for inpatient hospitalization and out-of-network treatment.
- Show your membership card to health care professionals before getting care from them.
- Pay the **Copayments** required by your plan.
- Promptly follow your plan's complaint processes if you believe you need to submit a complaint.
- Treat all **Providers**, their staff members and the staff of the plan with respect.
- Not be involved in dishonest activity directed at the plan or at any **Provider**.

Communicate

- Tell your health care professionals if you do not understand the treatment you receive and ask if you do not understand how to care for your illness.
- Tell your health care professionals promptly when you have unexpected problems or symptoms.
- Consult with your **PCP** for **Referrals** to nonemergency covered **Specialist** or **Hospital** care.
- Understand that network **Physicians** and other health care professionals who care for you are not employees of Aetna and that Aetna does not control them.
- Contact Member Services if you do not understand how to use your benefits.
- Give correct and complete information to **Physicians** and other health care professionals who care for you.
- Advise Aetna about other medical insurance coverage you or plan **Members** in your family may have.
- Ask your treating **Physician** about all treatment options.
- Ask about the **Physician's** compensation arrangement with Aetna.

You may have additional rights and responsibilities depending on state laws applicable to your plan.

Advance directives

An advance directive is a legal document that states your wishes for medical care. It can help doctors and family members determine your medical treatment if, for some reason, you can't make decisions about it yourself.

There are three types of advance directives:

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

(*Advanced Directives and Do Not Resuscitate Orders. American Academy of Family Physicians, March 2005. Available at* ***http://familydoctor.org/003.xml?printxml***)

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 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.

Additional information available upon request

In accordance with New York law, the following information is available to a **Member** or prospective **Member** upon request by contacting the Member Services department:

1. List of the names, business addresses, and official positions of the membership of the board of directors, officers, controlling persons, owners or partners of the plan.
2. The most recent certified financial statements of the plan, including a balance sheet and summary of receipts and disbursements prepared by a certified public accountant.
3. Copy of the most recent individual, direct-pay **Subscriber** contracts.
4. Information relating to consumer complaints compiled pursuant to Section 210 of the New York insurance law.
5. Procedures for protecting the confidentiality of medical records and other enrollee information.
6. Drug formularies, if any, used by the plan and the inclusion/exclusion of individual drugs.
7. Written description of the organizational arrangements and ongoing procedures of the plan's quality assurance program.
8. Description of the procedures followed in making decisions about experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials.
9. Individual health practitioner affiliations with **Participating Hospitals**, if any.
10. Upon written request, specific written clinical review criteria relating to a particular condition or disease and, where appropriate, other clinical information which the plan might consider in its patient management program and the plan may include with the information a description of how it will be used in the patient management process, provided, however, that to the extent such information is proprietary to the plan, the enrollee or prospective enrollee shall only use the information for the purposes of assisting the enrollee or prospective enrollee in evaluating the covered services provided by the plan.
11. Written application procedures and minimum qualification requirements for health care **Providers** considered by the plan.
12. Such other information as required by the Commissioner of Health provided that such requirements are promulgated pursuant to the state administrative procedure act.

Member participation

An Aetna plan **Member** is on the Board of Directors. This **Member** representative is an active participant in overseeing the management and operation of Aetna. Moreover, we regularly send surveys to **Members** requesting their views on the services received from **Participating Providers** and also seeking ideas and comments about their benefits, including Aetna's policies and procedures. We use this input to evaluate our services, policies and procedures.

Health Insurance Portability and Accountability Act

The following information is provided to inform you of certain provisions contained in the Subscriber Contract, 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 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 toward you or your dependents' other coverage). However, you must request enrollment within 31 days after you 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.

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