



AETNA ADVANTAGE PLANS FOR INDIVIDUALS, FAMILIES AND THE SELF-EMPLOYED

NEW PROVISIONS EFFECTIVE SEPTEMBER 23, 2010

This information is an addendum to the printed materials you received.

The federal health care reform legislation, known as the Patient Protection and Affordable Care Act, was signed into law on March 23, 2010 by President Obama.

The following health care reform changes are effective on September 23, 2010:

- Allow dependent coverage up to age 26
- Remove lifetime benefit limits – based on dollar amounts
- Take away cost-sharing obligations for preventive services (In network)
- Eliminate pre-existing condition exclusions for dependent children (under 19 years of age)

Please note that some previously printed materials do not reflect these changes. However, the new provisions **are in effect** for plans with an effective date on or after September 23, 2010, and your Aetna Advantage Plan **does comply** with the new federal health care reform legislation.

If you have any questions, please talk to your broker or call 1-800-MY-HEALTH.

Please note that in addition to health care reform changes, coverage for children only may no longer be available in your state. Also, all plans described in the printed material you received may not currently be available in your state.

Aetna Advantage Plans for Individuals, Families and the Self-Employed are underwritten by Aetna Life Insurance Company (Aetna) directly and/or through an out-of-state blanket trust or Aetna Health Inc. In some states, individuals may qualify as a business group of one and may be eligible for guaranteed issue, small group health plans. These plans are medically underwritten and you may be declined coverage in accordance with your health condition.

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QPOS® Individual Advantage Program



We want you to knowSM



New York Individual Advantage QPOS Program Summary of Benefits and Out-of-Pocket Costs

	NY Referred	NY Nonreferred
Financial		
Deductible: Single/Family	N/A	\$1,000/\$2,000
Member Coinsurance	N/A	20% for most items
Coinsurance Limit: Single/Family	N/A	\$3,000/\$5,000
Lifetime Maximum Benefit	N/A	\$500,000
Precertification Penalty	N/A	10% benefit reduction for failure to precertify
Primary Care Physician Visits		
Office Hours	\$10 Copay	20% after deductible
After Hours/Home Visits	\$10 Copay	20% after deductible
Specialty Care		
Office Visit	\$10 Copay	20% after deductible
Diagnostic Outpatient Testing	\$10 Copay	20% after deductible
Physical Therapy (90 visits/condition)	\$10 Copay	20% after deductible
Outpatient Surgery	\$10 Copay	20% after deductible
Hospitalization/Inpatient Hospice	No Copay	20% after deductible
Skilled Nursing Facility	No Copay	20% after deductible
Emergency Room	\$35 Copay	20% after deductible
Home Health Care (200 visits/calendar year)	\$10 Copay/Visit	20% (No deductible)
Outpatient Hospice Care (210 days/calendar year)	\$10 Copay/Visit	20% after deductible
Maternity		
Ob Visits	No Copay	20% after deductible
Delivery	No Copay	20% after deductible
Hospital	No Copay	20% after deductible
Mental Health		
Inpatient (30 days/calendar year)*	No Copay	Covered at 100%**
Outpatient (maximum 30 visits/calendar year + 3 emergency visits/calendar year)	10%/Visit	10% after deductible
Substance Abuse		
Detoxification (30 days/calendar year)*	No Copay/Admission	Covered at 100%**
Inpatient Rehabilitation	Not Covered	Not Covered
Outpatient Rehabilitation	Not Covered	Not Covered
Preventive Care		
Routine Eye Screening (in PCP's office)	\$10 Copay	20% after deductible
Routine Physicals	\$10 Copay	Not Covered
Immunizations	No Copay/\$10 Copay***	Not Covered
Routine Mammography	\$10 Copay	20% after deductible
Routine Gyn Exam	\$10 Copay	20% after deductible
Prescription Drugs	\$100/\$300 Deductible \$5 Copay/\$10 Copay ⁺	Not Covered
Durable Medical Equipment⁺⁺	No Copay	20% after deductible
Private Duty Nursing	Combined maximum for all inpatient and outpatient private duty nursing referred and non-referred services of \$5,000 per member per calendar year; \$10,000 per lifetime. \$10 per visit.	20% coinsurance after deductible per visit

Referred and nonreferred benefits do not duplicate each other. Refer to your Schedule of Benefits. To receive maximum benefits, in-network (referred) services must be provided or referred by the participating primary care physician you selected. All benefits are provided in accordance with the applicable plan document.



When it comes to your health, few things are as important as putting you and your physician in charge of your medical treatment. At Aetna Health Inc., we recognize the important role your physician plays as your medical advisor — one who knows you, your medical history and your personal health concerns.

Our goal is simple — to provide you with access to quality health care benefits, so that you and your doctor can focus on your medical care. We offer you the coverage, health information and support that help you get the most from your health plan.

How QPOS Works

QPOS gives you the freedom to choose any licensed physician or hospital each time you need a covered service, with or without a referral. Whether you prefer the guidance of your primary care physician (PCP) or the freedom to go directly to another provider — the choice is always yours.

There are two ways to access your covered benefits with QPOS — referred care and self-referred care.

Referred Care

Visit Your Primary Care Physician

You will minimize your out-of-pocket costs when you select a PCP from our provider network and use the PCP to coordinate your care within the network. Your PCP will provide your routine care and refer you to a network specialist or hospital, when necessary.

As your personal medical advisor, your PCP can:

- Provide routine and preventive care
- Treat you for illnesses and injuries
- Help you make important medical decisions
- Refer you to a specialist when needed

You may see your PCP whenever you need care, with only a copay+++ for each visit.

Selecting a PCP

To choose a PCP, log on to DocFind®, our online provider directory, at www.aetna.com, or refer to the Aetna physician directory. You can also change your designated primary care physician any time, for any reason, by visiting

DocFind or the Member Services page on our website. You can also call the toll-free number on your Aetna ID card.

If you use a participating provider, you never need referrals for:

- Routine and preventive care
- Well-baby visits
- Ob/Gyn care

Self-Referred Care

Self-Refer to any Physician or Specialist

With QPOS, you also have the freedom to visit *any* licensed provider, in or out of the Aetna network, *without a referral* for covered benefits. When you self-refer for covered services, you are responsible for an annual deductible and coinsurance.+++ You may need to file a claim form, and you may receive balance bills (the difference between the physician's actual fee and the amount covered by your plan).

*Inpatient mental health and substance abuse days are a combined maximum and offset each other.

**Member precertification required or benefits paid will be substantially reduced.

***No copay if the visit is in accordance with the Schedule of the American Academy of Pediatrics; for all other visits, there is a \$10 copay.

+\$5 copay generic drugs; \$10 copay brand-name drugs.

++Covered in accordance with Medicare guidelines.

+++Refer to your benefits summary for applicable copays, deductibles and coinsurance amounts and maximum benefit limitations.

Cost-Sharing for Self-Referred Care

Several requirements generally apply to coverage for self-referred care, depending on your specific plan:

1. You must meet an annual deductible before benefits are covered; then
2. Your coverage is subject to coinsurance until you reach your applicable coinsurance maximum, if any; then
3. You are covered for the reasonable and customary amount for all other covered benefits (up to the maximum benefit) for the balance of the year subject to the lifetime maximum benefit of your specific plan. Certain charges, including your deductible, do not apply toward the coinsurance maximum.

Precertification for Self-Referred Care

When you *self-refer* to any physician in or out of our provider network, you must also obtain authorization from Aetna called *precertification*, **prior** to receiving certain self-referred medical services. Preauthorization will determine if the services you are going to receive are covered services under your plan. Failure to precertify your services may lead to substantially reduced benefits, or denial of coverage. After you enroll, refer to your plan documents for a list of medical services that require precertification.

Non-duplication of Benefits

Whether you receive referred or self-referred care services, all benefits that you receive under the QPOS program will be applied in calculating the maximum benefit that you are entitled to receive under the program. Benefits offset and do not duplicate each other.

Broad Spectrum of Benefits*

You enjoy all the benefits of the Aetna QPOS program:

- Routine checkups and preventive care
- Specialty care
- Hospitalization and surgery**
- Diagnostic testing
- Emergency care — anytime, anywhere (In case of emergency, call 911 or the local emergency hotline, if available)
- Limited mental health and substance abuse benefits

Quality Point-of-Service Options	
PCP-Coordinated Care	Self-Referred Care
You go to your PCP. You obtain a referral to a participating specialist or hospital.	You go directly to any physician or hospital for a covered service <i>without a referral</i> .
The <i>provider</i> obtains preauthorization from the plan. You pay the applicable copay amount.	You are required to obtain preauthorization
	You are subject to a deductible and coinsurance and an annual maximum limit.
Maximize your coverage. No claim forms. No deductible. No balance bills.	Maximize your choice. Possible claim forms. Deductible/coinsurance. Possible balance bills.

*Some benefits are subject to limitations or visit maximums. You or your provider may be required to precertify or obtain prior approval of coverage for certain services such as nonemergency inpatient hospital care, including mental health and substance abuse services.

Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee 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. They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received upon enrollment) are not covered, and medical exceptions are not available for them.

*Informed Health Line nurses can only provide basic medical information. They cannot diagnose, prescribe or give medical advice. Specific questions should be addressed by your doctor.

**Vision One is a registered trademark of Cole Managed Vision.

***Availability varies by service area.

Special Programs To Help You Take Control of Your Health

You also have access to special programs and discounts:

- Reminders for important checkups, immunizations and preventive care screenings
- Ongoing education and support for chronic conditions such as asthma, heart failure, diabetes and low back pain
- Age-appropriate cancer screenings for age-eligible members
- Programs that support women's unique health care needs
- Moms-to-Babies™ Maternity Management Program
- Informed Health® Line, a 24-hour, toll-free number that links you to a team of experienced registered nurses who can provide information on a variety of health issues*
- Vision One®** program for discounts on eyeglasses, contact lenses, Lasik surgery and nonprescription eyewear
- Alternative health care programs, for savings on a variety of health products and services; in addition, the Natural Alternatives program offers savings on visits to acupuncturists, chiropractors and massage therapists***
- Fitness program for savings on health club memberships and home exercise equipment

- National Medical Excellence Program® to help eligible members access covered treatment for solid organ and bone marrow transplants, coordinate arrangements for treatment of members with certain rare or complicated conditions at certain tertiary care facilities across the country when those services are not available within 100 miles of the members' home, and assist members in accessing emergency medical care when they are traveling temporarily outside of the United States

Prescription Coverage

Medically necessary prescription drugs are covered subject to applicable limitations and exclusions. Take your prescription and Aetna ID card to any participating pharmacy to obtain covered prescription drugs. Each prescription is limited to a maximum 34-day supply. After you pay a calendar year deductible (\$100 for yourself or \$300 for your family), you will pay:

- \$5 copay for covered generic drugs
- \$10 copay for covered brand-name drugs

Drugs on the Formulary Exclusions List are not covered unless a medical exception is obtained by your doctor.

Visit DocFind on our website at www.aetna.com to locate participating pharmacies in your area. The formulary is a list of prescription drugs that includes hundreds of generic and brand-

name drugs covered by the plan. You can review our formulary on our website. After you enroll, you'll receive the Aetna Medication Formulary Guide, which lists our formulary medications. Our formulary is subject to change. Your coverage is not limited to drugs on the formulary.

Prescription drugs in the limitations section of your plan documents and nonprescription drugs are not covered. These drugs are not subject to the medical exceptions appeal process.

In an emergency, if you need to fill a prescription at a nonparticipating pharmacy located beyond a 50-mile radius of your QPOS service area, you will need to pay the full charge of the prescription and submit a claim to Aetna. Your reimbursement, which is subject to professional review, is 100 percent of the reasonable cost of the prescription, less applicable deductible and copay. At a participating pharmacy outside of your QPOS service area, present your ID card and pay any applicable deductible and copay.

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Aetna Navigator™ — www.aetnavigators.com

Giving You the Power To Manage Your Health Care

Aetna Navigator provides a single location for the health and medical issues that matter most to you.

In one easy-to-use website, you can perform a variety of self-service functions and take advantage of a vast amount of health information from Aetna IntelliHealth®,* one of the most trusted and comprehensive health sites available today, offered in association with Harvard Medical School and the University of Pennsylvania School of Dental Medicine.

Log on to www.aetnavigators.com today and check out some of Aetna Navigator's distinct features:

- A wealth of health information from Aetna IntelliHealth, a premier provider of online consumer-based health, wellness and disease-specific information
- Online customer service functions that allow you to change your primary care physician or primary care dentist, order ID cards and send e-mail inquiries to Member Services
- Interactive "Cool Tools," including a medical dictionary, allergy and asthma quizzes, a pregnancy due-date calculator, and a heart and breath odometer
- A preventive care planner that includes recommendations for screenings and immunizations

Enrolling Is as Easy as 1, 2, 3

Once you review your enrollment materials:

1. Fill out the enrollment form completely and sign where indicated. Be sure to read both sides.
2. Choose a PCP for yourself and each covered member of your family.
3. After your effective date of coverage, use the member copy of your enrollment form as a temporary membership card until you receive your permanent card.

After You Enroll

You will receive a member ID card after your enrollment form is processed. Carry the card with you as proof of coverage. You will also receive materials explaining how to use the plan. Refer to these materials, as well as your plan documents, when you have questions about your Aetna benefits, limitations, exclusions and other details.

*Information provided through Aetna IntelliHealth (www.intelihealth.com) is provided "AS IS" without warranty of any kind, either express or implied, including without limitation, the implied warranties of merchantability or fitness for a particular purpose, and is presented without any warranty as to its reliability, accuracy, timeliness, usefulness or completeness. Aetna assumes no responsibility for any circumstances arising out of the use, misuse, interpretation or application of any information supplied by Aetna IntelliHealth. Information supplied by Aetna IntelliHealth is for informational purposes only, is not medical advice and is not intended to be a substitute for medical care provided by a physician.

Member Confidentiality

Aetna considers nonpublic personal member information (NPI) confidential and has policies and procedures in place to protect the information against unlawful use and disclosure. When necessary for your care or treatment, the operation of your health plan, or other related activities, we use NPI internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (employers who sponsor self-funded health plans, health care provider organizations, and others who may be financially responsible for payment for the services or benefits you receive under your plan), vendors, consultants, government authorities and their respective agents. These parties are required to keep NPI confidential as provided by applicable law. Participating network/preferred providers are also required to give you access to your medical records within a reasonable amount of time after you make a request. To obtain a copy of our notice describing in greater detail our practices concerning use and disclosure of NPI, please call the toll-free Member Services number on your ID card or visit our Internet site at www.aetna.com.

Pre-Existing Conditions and Limitations

For a period of twelve (12) months following the date that an individual files a substantially complete application for coverage and before the first day of coverage, coverage is excluded for any service obtained by or on behalf of a member for conditions of the member (whether physical or mental), regardless of the cause of the condition for which medical advice, diagnosis, care or treatment was recommended or

received, during the six (6) months immediately preceding the enrollment date, or for a period of 10 months as to a pregnancy existing on the effective date of coverage. However, any time the member was previously covered under a previous health insurance plan or policy, health maintenance plan or employer-provided health benefit arrangement, if the previous coverage was continuous to a date of coverage, it shall be credited to the member. The pre-existing condition limitation will not apply if you:

- Just converted your coverage from an Aetna HMO group coverage benefits plan; or
- Are an “eligible individual” under the Health Insurance Portability and Accountability Act (HIPAA) (see section 2741 [b] of the Federal Public Health Services Act). Refer to your plan documents for more information.

What's Not Covered

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. Some benefits listed as excluded are available on an optional basis to the contract-holder and may be covered when purchased in addition to the medical plan by the contract-holder.

Services and supplies not covered include, but are not limited to, the following:

- Pre-existing conditions as described above
- Cosmetic surgery, including breast reduction
- Custodial care
- Hearing aids

- Experimental or investigational procedures or treatments
- Routine foot care
- Infertility services (except surgical and medical care for diagnosis and treatment of correctable medical conditions otherwise covered by this contract) including, but not limited to, in vitro fertilization procedures, Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), unless specifically listed as covered in the plan documents
- Dental care or treatment or X-rays, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident, or care or treatment necessary due to congenital disease or anomaly
- Treatment of mental retardation
- Substance abuse rehabilitation
- Reduction of nails, calluses or corns
- Rehabilitation therapies (including, but not limited to, occupational, speech and cardiac therapy) except for physical therapy
- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents

See your plan documents for a complete list of exclusions.

Aetna

1425 Union Meeting Road
Mailstop U36A/Triad 24
PO Box 963
Blue Bell, PA 19422

Member Services

1-800-435-8742
TDD# 1-800-628-3323
(Hearing Impaired Only)

Spanish-Speaking Hotline

1-800-533-6615

Translation of this material into another language may be available. For assistance, please call Member Services at 1-800-435-8742/TDD 1-800-628-3323.

Puede estar disponible la traducción de este material en otro idioma. Por favor, para ayuda llame a Servicios al Miembro al 1-800-435-8742/TDD 1-800-628-3323.

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 or dental services and, therefore, cannot guarantee any results or outcomes. Consult the plan documents (Schedule of Benefits, Certificate of Coverage) 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. Participating providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law. Certain primary care providers are affiliated with integrated delivery systems or other provider groups (such as independent practice associations and physician-hospital organizations), and members who select these providers will generally be referred to specialists and hospitals within those systems or groups. However, if a system or group does not include a provider qualified to meet member's medical needs, member may request to have services provided by non-system or non-group providers. Member's request will be reviewed and will require prior authorization from the system or group and/or Aetna to be a covered benefit.

QPOS referred and self-referred benefits may be provided or administered by Aetna Health, Inc. or Aetna Health Insurance Company of New York. Some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify, or obtain prior approval of coverage for certain services such as non-emergency inpatient hospital care. Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee 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. They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received upon enrollment) are not covered, and medical exceptions are not available for them.

While this material is believed to be accurate as of the print date, it is subject to change.

