Make Aetna the choice for your health!

New Jersey State Health Benefits Program

Everything you need to help you be your healthiest.

Effective April 2008
Welcome to Aetna!

There’s nothing more important than you and your family’s health. And now’s a great time to review your options to make sure you pick the plan — and the company — that makes the healthy difference.

We’ve put together some material to help you better understand our program, and how it can help you and your family.

If you have questions, we’re here for you. Just call us at 1-877-STATENJ or visit us day or night at www.aetna.com/statenj.

Benefits snapshot

When you choose Aetna, you’re choosing a lot more than simple benefits coverage. You’re also getting access to leading technology and programs that help you take charge of your health — conveniently, and at a cost you can afford.

Here are some of the highlights of your Aetna plan:

- Over 20,000 participating providers in New Jersey alone! Plus, over 490,000 providers and 2,200 hospitals nationwide.
- Primary care physician (PCP) or specialist visits for just a copay.
- Emergency care — anytime or anywhere you need it.
- Coordination with top physicians and facilities to provide transplant care when it’s not available locally (National Medical Excellence Program®)
- Special coverage and services for women, like direct access to Ob/Gyns — without a referral. And our Beginning RightSM Maternity Program helps support growing families.
- Mailed reminders to get regular check-ups for breast, colorectal and cervical cancer, based on your age.
- Toll-free chats with a registered nurse to get your health questions answered anytime, day or night at 1-800-556-1555.
- 30+ programs to help you manage your asthma, diabetes, heart disease, low back pain and other health conditions.
- Data tools that provide medical alerts or suggestions to your doctor or pharmacist based on your health history with us (MedQuery®).
- An online wellness program that can help you stop smoking, eat better, relieve stress and much more (Simple Steps To A Healthier Life®)
- A drug plan with a copay of $5/$10/$20 per prescription for the employees of local employers who do not offer it.
- Technology to help you manage your health, and your benefits. You can request an ID card (www.aetna.com), find a doctor (www.aetna.com/docfind/custom/statenj) … even browse plenty of health topics that matter most to you (www.intelihealth.com).

‡ Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, which may include Aetna Health Inc., Aetna Health Insurance Company and/or Aetna Life Insurance Company (Aetna).
Top 5 reasons to choose Aetna

There are lots of good reasons to choose us for you and your family. But here are the ones we think you’ll like best:

1. **The doctor you want** – Aetna’s big network, both nationwide and in New Jersey, likely has the doctor most important to you — YOURS.

2. **Worry-free coordination of care** — Don’t know which specialist to visit? You’ve got your very own PCP to help you!

3. **Plenty of perks** — Discounts galore on Jenny Craig®, Pearle Vision® and other eyewear locations, hearing aids, spa gift certificates, and more!

4. **One-stop health history**: The online Personal Health Record (PHR) is all your hard-to-find health information in one easy-to-find spot. Share it anytime with your doctor.

5. **Benefits information in seconds**: Accessing your benefits is just a quick click away at www.aetna.com. You can check claims status, order ID cards, find a specialist, and much more.

Got questions? Get answers!

Call 1-877-STATENJ or visit www.aetna.com/statenj. We look forward to helping you and your family maintain their best health. Don’t forget to sign up for Aetna at open enrollment!
**Health Benefit Plan — Benefit Copay Sheet**

<table>
<thead>
<tr>
<th>Type of Service or Supply</th>
<th>Benefit Level*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Out-of-Pocket Maximums</strong></td>
<td>No lifetime maximum</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Services</strong></td>
<td>Covered in full — no copay</td>
</tr>
<tr>
<td>Room and Board</td>
<td>Covered in full — no copay</td>
</tr>
<tr>
<td>X-ray and Lab Tests</td>
<td>Covered in full — no copay</td>
</tr>
<tr>
<td>Special Care Units</td>
<td>Covered in full — no copay</td>
</tr>
<tr>
<td>Maternity Care</td>
<td>Covered in full — no copay</td>
</tr>
<tr>
<td>Well-Baby Care</td>
<td>Covered in full — no copay</td>
</tr>
<tr>
<td>Skilled Nursing Facilities</td>
<td>Covered in full — no copay</td>
</tr>
<tr>
<td>Birthing Centers</td>
<td>Covered in full — no copay</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Covered in full — no copay</td>
</tr>
<tr>
<td><strong>Surgery and Anesthesia</strong></td>
<td>Covered in full — no copay</td>
</tr>
<tr>
<td>Inpatient Surgery</td>
<td>Covered in full — no copay</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>Covered in full — no copay</td>
</tr>
<tr>
<td><strong>Outpatient Treatments</strong></td>
<td>Copay applies per visit</td>
</tr>
<tr>
<td>Office Visit Copays: Primary Care Physician</td>
<td>Copay applies per visit with referral</td>
</tr>
<tr>
<td>Specialists</td>
<td>Copay applies per visit — no referral needed for all routine gynecological services</td>
</tr>
<tr>
<td>Ob/Gyn</td>
<td>Copay applies per visit</td>
</tr>
<tr>
<td>Doctor’s Home Visits</td>
<td>Covered in full</td>
</tr>
<tr>
<td>X-ray and Lab Tests</td>
<td>Copay applies per visit</td>
</tr>
<tr>
<td>Cardiac Rehabilitation, Chemotherapy, Dialysis or Radiation</td>
<td>Covered in full — 60 visits per condition, per calendar year/copay applies per visit</td>
</tr>
<tr>
<td>Physical, Speech, and Occupational Therapy</td>
<td>Copay applies per visit — 20 visits per year (Jan. through Dec.)</td>
</tr>
<tr>
<td>Licensed Chiropractor</td>
<td>Covered in full — copay applies per visit</td>
</tr>
<tr>
<td>Routine Examinations</td>
<td>Covered in full — copay applies per visit</td>
</tr>
<tr>
<td>Routine Well-Baby Care</td>
<td>Covered in full — copay applies per visit</td>
</tr>
<tr>
<td>Immunizations</td>
<td>Covered in full — copay applies per visit</td>
</tr>
<tr>
<td>Eye Examinations (no hardware)</td>
<td>Covered in full — copay applies per visit</td>
</tr>
<tr>
<td>Hearing Examinations</td>
<td>Covered in full — copay applies per visit</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Covered in full — no copay</td>
</tr>
<tr>
<td>Podiatry (nonroutine)</td>
<td>Covered in full — copay applies per visit</td>
</tr>
<tr>
<td><strong>Mental and Nervous Conditions</strong></td>
<td>35 days per year (Jan. through Dec.) covered in full — no copay</td>
</tr>
<tr>
<td>Inpatient Treatment</td>
<td>30 visits per year (Jan. through Dec.) covered in full — copay applies per visit</td>
</tr>
<tr>
<td>Outpatient Treatment</td>
<td>Covered in full — for acute residential treatment only</td>
</tr>
<tr>
<td>Alternate Care Facilities</td>
<td></td>
</tr>
<tr>
<td><strong>Treatment of Alcohol and Drug Abuse</strong></td>
<td>28 days per occurrence covered in full — no copay</td>
</tr>
<tr>
<td>Inpatient Treatment</td>
<td>60 visits per year (Jan. through Dec.) covered in full — no copay</td>
</tr>
<tr>
<td>Outpatient Treatment</td>
<td>Covered in full — no copay</td>
</tr>
<tr>
<td>Detoxification</td>
<td></td>
</tr>
<tr>
<td><strong>Other Services</strong></td>
<td>Covered in full — copay applies per visit</td>
</tr>
<tr>
<td>Infertility Services: Diagnosis</td>
<td>Covered with limitations — copay applies per visit</td>
</tr>
<tr>
<td>Treatment</td>
<td>Covered under Home Care</td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>Covered when medically necessary — copay applies</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>24-hour/7-day-a-week access to medical professionals via an 800 number</td>
</tr>
<tr>
<td>Informed Health Line</td>
<td>Covered when medically necessary — no copay</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>Covered when medically necessary — copay applies</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>Covered in full — copay/ waived if admitted</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>Not covered</td>
</tr>
<tr>
<td>Dental Services: TMJ</td>
<td>Not covered — except bony impactions</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td></td>
</tr>
<tr>
<td><strong>Wigs in connection with treatment of disease by radiation or chemicals</strong></td>
<td>$500/year</td>
</tr>
</tbody>
</table>

*See materials distributed by State Health Benefits Program for copay amounts.*
Choice, value, convenience in one easy-to-use plan

Aetna Prescription Drug Benefits

A pharmacy plan that’s easy to understand, easy to use, and easy on your budget
The medicine you can afford

STEP 1: Visit a participating pharmacy
Choose from over 55,000 chain and independent pharmacies*, including CVS/pharmacy®, Walgreens and Albertsons®. You can find a participating pharmacy at www.aetnapharmacy.com. Or, call 1-888-872-3862 to request a directory.

STEP 2: Give the pharmacists your prescription and ID card
You'll get your ID card after you enroll.

STEP 3: Pay the right amount
When you visit a network pharmacy, you pay a copayment for each prescription — either a standard, flat fee or a percentage of the discounted amount negotiated between Aetna and the pharmacy. You don’t have to submit a claim form!

If you visit a non-network pharmacy, you pay full price for the prescription and submit a claim for reimbursement. Your reimbursement depends on your plan design. See the enclosed Plan Design and Benefits summary for your copayment and reimbursement amounts.

Here's how it works …

Here's an Aetna+ prescription drug benefits and insurance plan that offers three pricing levels to help you and your doctor keep your costs low.

You pay one copay for generic and brand-name drugs that aren't on the Preferred Drug List, a lower copay for brand-name drugs on the Preferred Drug List, and an even lower copay for generic drugs on the Preferred Drug List. Now that's choice!

What a great way to complement your health benefits and health insurance plan!

*Aetna Region Network Profile (3/1/06).

†Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. The Aetna companies that offer or underwrite benefits coverage include: Aetna Health Inc., Aetna Health of California Inc., Aetna Health of the Carolinas Inc., Aetna Health of Illinois Inc., Aetna Health Insurance Company of New York, Corporate Health Insurance Company and/or Aetna Life Insurance Company; and in Arizona and Texas by Aetna Health Inc., Corporate Health Insurance Company and/or Aetna Life Insurance Company. For self-funded accounts, benefits coverage is offered by your employer, with administrative services only provided by Aetna Life Insurance Company.

Policy forms issued in Oklahoma include: HMO/OK COC-4 09/02, HMO/OK GA-3 11/01, CHI/OK GP-3 02/02, CHI/OK INSC-4 01/02, GR-23 and/or GR-29.

CVS/pharmacy is a registered trademark of CVS Corporation. Albertsons is a registered trademark of Albertsons, Inc.
Prescriptions that are safe and appropriate

The Preferred Drug List: safety, effectiveness, value
Your plan uses a Preferred Drug List — generic and brand-name drugs that are covered by your plan on a preferred basis. We’ve chosen each one based on quality and cost-effectiveness and they’re all approved by the U.S. Food and Drug Administration (FDA).

To view the preferred list online or learn how preferred drugs are chosen, visit www.aetnapharmacy.com or call the toll-free number on your ID card. If you are not yet a member, see your benefits administrator.

Special services for your prescription needs

Three more ways to safety
This plan includes three strategies** to help you find safe, appropriate and cost-effective medications. Most doctors are familiar with them and can handle them for you.

- **Precertification** — Your doctor gets approval from Aetna before prescribing certain drugs.
- **Step-therapy** — You try one or more clinically equal drugs used to treat your condition (in many cases less expensive) before the original drug is covered.
- **Quantity limits** — Your doctor gets approval for more medication than the FDA recommends.

Bring the pharmacy to your mailbox

For medications you take regularly to treat ongoing conditions such as arthritis, asthma, diabetes or high cholesterol, the Aetna Rx Home Delivery® service can deliver them directly to your home. Log on to www.aetnapharmacy.com for details.

Here are the advantages:

- Shipping is quick, confidential and free.
- Registered pharmacists check all prescriptions for accuracy and are available to answer questions anytime, night or day.
- Ordering, including online refills, is simple.
- Toll-free customer assistance is there for you.
- You may save a month’s copay on a 90-day supply.***

Using generic drugs might save you money.

Generic drugs typically cost you less than brand-name drugs. But don’t think that saving money means compromising safety and effectiveness. Even though many generics look different in color, shape or size, all are approved by the FDA and contain the same active ingredients as the brand-name drug. In fact, generic drugs must pass all the same safety and effectiveness trials that brand-name drugs do!

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**Medications on the Precertification, Step-therapy, and Quantity Limits lists are subject to change in accordance with applicable state law. Precertification and Step-therapy programs do not apply in Indiana or Maine. Step-therapy is not available in New Jersey. This definition of Precertification is not the same as the definition used by Texas law. Precertification is not a guarantee of payment or “verification” as defined by Texas law.

***Certain states require that prescriptions for more than a 30-day supply be available through a participating retail or mail-order pharmacy for the same copayment. Consult your benefits plan documents for details.
Specialty medications are delivered, when you need them
Some medications used to treat chronic conditions like rheumatoid arthritis, cancer, hemophilia, multiple sclerosis, and hepatitis C are not always available at retail pharmacies.

Working closely with your doctor, the Aetna Specialty Pharmacy™ service can deliver injectables and other specialty medications right to your home or doctor’s office. And, you get access to a team of registered pharmacists, nurses, benefit specialists, and patient care coordinators who know your benefits and can offer support. See www.aetnapharmacy.com for more information.

Reliable information at your fingertips
For even more information about home delivery and ways to manage your health and your budget, log on to www.aetnapharmacy.com. You’ll learn about:
- Possible medication side-effects
- Generic drug substitutions
- Drug safety and how to prevent harmful drug interactions
- Tips for saving money and answers to frequently asked benefits questions
- Specialty injectable drugs
And once you’re an Aetna member, you can register for your secure Aetna Navigator™ member website, available through www.aetnapharmacy.com, to estimate prescription drug costs and view detailed information about your claims.

Medically Necessary Prescriptions
This plan generally covers medications that are prescribed for medical needs. It also covers certain supplies that are considered medically necessary — such as diabetic supplies.

However, it’s important to note that this prescription drug plan does not cover everything your doctor might prescribe. For example, drugs prescribed for cosmetic purposes or for enhancing physical performance are typically not covered. We also don’t cover replacement of lost or stolen prescriptions. And over-the-counter medications and products are only covered if your state requires us to cover it. You can find out what specific products are not covered by reviewing your plan documents, which you will receive after you enroll. You can also check with your plan administrator if you have a specific question before enrollment.

For a complete listing of medications not covered by this prescription drug benefits plan, refer to your plan documents after enrollment.

If you have questions about a specific medication, ask your doctor. If you have questions about your Aetna plan, contact Member Services or your benefits administrator.

Learn more about Aetna prescription drug benefits at www.aetnapharmacy.com.
Health benefits made simple

Health Network Only

HMO Plan

Easy-to-use benefits
One-on-one care
It’s a good idea to work with a primary care physician. He or she will learn your health needs better than anyone. And you’ll get the best care.

A primary doctor

Here’s an easy-to-use HMO* health benefits plan from Aetna.† You see your primary care doctor. And you never have to file claim forms!

It’s as simple as this:

STEP #1

Choose a PCP

- A primary care physician (PCP**) is a doctor you go to first. He or she can learn about your health and help you manage it.
- You can choose any PCP from Aetna’s network — it’s your choice. Plus, you’ll feel good knowing that anyone you choose meets our standards.
- Choosing a doctor is a personal decision — that’s why each member of your family can have his or her own PCP.
- Change your PCP anytime. Call Member Services at the number on your ID card. Or visit our Aetna Navigator™ member website at www.aetna.com.
- You must choose a PCP and see network providers to receive benefits from this plan.

STEP #2

Visit your PCP for care

- Go to your PCP for check-ups or whenever you are sick or hurt.
- Your PCP will help you decide if you need care from another doctor. If so, your PCP will give you a referral.
- Sometimes you may need care that requires approval from Aetna before you get it. This is called precertification***. Your PCP and other doctors will get this okay for you.

*In Washington, the product referred to as HMO is called Primary Choice™ and is offered by Aetna Health Inc., a licensed health care service contractor.

**In Washington, PCP refers to primary care provider.

***In Texas, this approval is known as “pre-service utilization review” and is not “verification” as defined by Texas law.

‡ Health benefits plans are offered or administered by: Aetna Health Inc., Aetna Health of California Inc., Aetna Health of the Carolinas Inc. and/or Aetna Health of Illinois Inc.; and in Arizona and Texas, by Aetna Health Inc. For self-funded accounts, benefits coverage is offered by your employer, with administrative services only provided by Aetna Life Insurance Company.
will guide your way

**STEP #3**

**Pay your copay**

- When you visit your PCP or a specialist, you pay a copay. This is a flat dollar amount, or a percentage of your covered services.

- Your Plan Design and Benefits summary lists your covered services and your copay amount. Take a look to find out how much you will pay.

**Feel good about your health care decisions. Our online services can help.**

**Find a doctor, fast!**

With our DocFind® online directory, you can look for a doctor by specialty and location. Need to find a pediatrician near home? How about a surgeon who works with a nearby hospital? All the information is here — plus maps and directions to the doctor’s office. You can even look for doctors who speak your language.

**Do you need a printed directory?**

If you are already an Aetna member, 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).

**Manage your health with our members-only website.**

Need to learn the average cost of a medical procedure or service? Want to track a claim? It’s easy with our secure Aetna Navigator member website.

- Compare hospitals in your area or anywhere in the country.

- See medical costs and prescription prices.

- Help yourself stay well by making healthy changes to your lifestyle.

- Read health information from Harvard Medical School.

- Look through our online encyclopedia for information about hundreds of health conditions.
Visit Aetna Navigator today, or take the FREE tour

If you’re already an Aetna member, go to www.aetna.com, enter your user name and password, and click “Go.” If you’re not registered yet, click on “Register Now.”

Not an Aetna member? Click on “Members: Secure Information,” and then “Take a site tour to learn more.”

It’s easier to make good decisions about your health when you have the right information

Have a health question in the middle of the night?

Contact our Informed Health® Line, anytime, 24/7. Registered nurses are there to help. They can give you the information you need to work with your doctor. Then you can make health care decisions. Just call, toll free, 1-800-556-1555.

While only your doctor can diagnose, prescribe or give medical advice, Informed Health Line nurses can offer information on more than 5,000 health topics. Always consult your doctor first with questions or concerns about your health care needs.

Make the simple choice.

Enroll today!
Stay well, get fit and save money

Discount Programs and Services
From Aetna

Included with your health plan — great deals on fitness, vision, hearing, complementary products and services, and more
Good health can mean more than visiting the doctor

Who said nothing in life is free? Enroll in one of our health benefits or health insurance plans and get — at no added cost — the Aetna extras! Our discount programs and services are your ticket to the small luxuries that can keep you happy and healthy.

Save right away on:
- Fitness club memberships
- Treadmills and elliptical trainers
- LASIK surgery
- Massage therapy
- Colored contact lenses
- And more!

‡Health benefits and health insurance plans are offered, underwritten or administered by Aetna Health Inc., Aetna Health of the Carolinas Inc., Corporate Health Insurance Company, Aetna Health Insurance Company of New York and/or Aetna Life Insurance Company.
Good health can mean more than visiting the doctor. Regular exercise can help you stay healthy, and can make you look and feel better. With our Fitness Program, you can save money, too! It’s easy to get started once you’ve enrolled with Aetna.

**Pick a club – join a club**

Enjoy preferred rates on fitness club memberships* in the GlobalFit™ network. With over 2,000 locations**, it’s easy to find one near you. Features like a FREE guest pass*** and flexible membership options can help you get started. Here’s how …

**Step #1:** Visit www.globalfit.com/fitness for a list of participating clubs.

**Step #2:** Choose a club and follow directions to a FREE guest pass (available at most clubs). It’s your sneak peek at the club culture, services and equipment.

**Step #3:** Enroll online, or call GlobalFit toll free at 1-800-298-7800.

***More reasons to join our Fitness Program***

- Flexible memberships, with month-to-month and 48-week options
- Convenient billing through your bank account or major credit card
- Guest privileges at participating clubs when traveling for 48-week members
- Savings on home exercise equipment and videos
- At-home weight loss and one-on-one health coaching† programs.

A daily dose of exercise keeps your heart healthy, your bones strong — and may help you get a better night’s sleep.

*Membership to a club of which you are a current member is not available. Membership also may not be available to a club if you have been a member of that club within the past 12 months.


***Not available at all clubs.

†Provided by WellCall, Inc.
A vision program for eye-opening savings

See your way to bigger savings!

You’ll pay less for eyeglasses, contact lenses, solutions, even LASIK eye surgery. You’ll even save on specialty items not typically covered by insurance — like snazzy eyeglass chains, designer frames, sunglasses and colored contact lenses.

Enroll with Aetna, and use your discount each time you visit a participating store. Just book, browse and save!

- **Book** — Make an appointment or go to a participating store. Choose from a large network of providers including participating Sears Optical, Target Optical®, JCPenney® Optical, LensCrafters®, Pearle Vision®, as well as thousands of independent optometrists and ophthalmologists.
- **Browse** — Choose from fashionable frames and the latest in lens technology.
- **Save** — Show your Aetna ID card for instant savings.

Save on LASIK surgery

LASIK surgery just got more affordable. You’ll save up to 15%. Plus, you’ll get education, an initial screening and follow-up care — all in one discounted price. The initial consultation is always free. Call 1-800-422-6600.

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This is a brief listing of the savings* you can receive through Aetna Vision℠ Discounts.

<table>
<thead>
<tr>
<th>PRODUCT OR SERVICE</th>
<th>WHAT YOU’LL PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eye Exams for Plans</strong></td>
<td></td>
</tr>
<tr>
<td>That Cover Eye Exams</td>
<td>Refer to your health benefits plan documents for coverage details</td>
</tr>
<tr>
<td><strong>Eye Exams for Plans That Do Not Cover Eye Exams</strong></td>
<td></td>
</tr>
<tr>
<td>- Comprehensive eye exam</td>
<td>$42</td>
</tr>
<tr>
<td>- Standard contact lenses fit &amp; follow up</td>
<td>$40 (plus $42 exam fee)</td>
</tr>
<tr>
<td>- Specialty contact lenses fit &amp; follow up (e.g. Toric, Bifocal, Gas Permeable)</td>
<td>$10 off retail (plus $42 exam fee)</td>
</tr>
<tr>
<td><strong>Lenses per Pair (uncoated plastic)</strong></td>
<td></td>
</tr>
<tr>
<td>- Single Vision</td>
<td>$40</td>
</tr>
<tr>
<td>- Bifocal</td>
<td>$60</td>
</tr>
<tr>
<td>- Trifocal</td>
<td>$80</td>
</tr>
<tr>
<td>- Standard Progressive (no-line bifocal)</td>
<td>$120</td>
</tr>
<tr>
<td><strong>Eyeglass Frames (retail prices)</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>40% off retail prices</td>
</tr>
<tr>
<td><strong>Lens Options per Pair (add to lens price above)</strong></td>
<td></td>
</tr>
<tr>
<td>- Standard polycarbonate (includes UV coating and scratch-resistant coating)</td>
<td>$40</td>
</tr>
<tr>
<td>- Scratch-resistant coating</td>
<td>$15</td>
</tr>
<tr>
<td>- Ultraviolet (UV) coating</td>
<td>$15</td>
</tr>
<tr>
<td>- Solid or gradient tint</td>
<td>$15</td>
</tr>
<tr>
<td>- Standard antireflective coating</td>
<td>$45</td>
</tr>
<tr>
<td>- Glass</td>
<td>20% off retail</td>
</tr>
<tr>
<td>- Photochromic Glass</td>
<td>20% off retail</td>
</tr>
</tbody>
</table>

Contact Lenses

Get a 15% discount (5% on disposables) off retail prices.

Mail-Order Contact Lens Replacement Program

Call 1-800-391-LENS (5367) to order replacement contact lenses. (Mail-order contact pricing is not subject to the discounts received at participating locations.)

Additional Vision-Related Items

Visit any participating location to receive a 20% discount off retail prices.

LASIK Procedure

Save up to 15% off the surgeon’s fee through the U.S. Laser Network.

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*EyeMed Services and Compensation Schedule, 7/06. Prices are subject to change.
A complementary health care program
to relax, recharge and save!

Few people travel the same path to good health. That's why the Aetna Natural
Products and Services℠ program delivers savings on complementary health services
and natural products through American Specialty Health Networks, Inc., a recognized
leader in this market.

It's a smart way to save on items not typically covered by insurance.

**Massage therapy**

Lower your stress, improve your health, relieve your aching muscles — and save.

**Acupuncture**

Pinpoint your pain or stress with this 5000-year-old therapy, for less.

**Chiropractic care**

Get realigned with savings on regular chiropractic visits.

**Dietetic counseling**

Eat healthier. Look leaner. Feel better. Registered dieticians can show you how.

**Natural products**

Get a discount on your daily dose of over-the-counter vitamins, aromatherapy, yoga
equipment, and nutritional and health supplements, and more.
A hearing discount program to hear the world clearly

Hear the world clearly with Aetna HearingSM Discounts. You save on the latest hearing aid styles and technologies. You also get 40% off the retail price of hearing exams and hearing aid services.

It's not insurance, so there's no need for referrals or claims. You'll get:
- Savings on many styles, from complete canal to behind-the-ear aids
- Savings on new technology, including programmable and digital instruments
- Discounts on hearing aid repairs
- Free follow-up service for one year
- Over 1,500* locations nationally

Remember, if your health benefits or health insurance plan covers hearing aids or exams, follow your plan’s instructions first.

Typical prices* for hearing aids**

Here are the typical prices you'll pay for hearing aids — after the applied discount. Visit www.aetna.com or call HearPO customer service (weekdays, 9 a.m. to 6 p.m. ET) at 1-888-HEARING (1-888-432-7564) for more information.

<table>
<thead>
<tr>
<th>Level</th>
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<th>In The Ear</th>
<th>In The Canal</th>
<th>Complete In The Canal</th>
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<td>$1,995 – $2,595</td>
<td>$1,995 – $2,695</td>
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*HearPO website, www.hearpo.com/aetna, 1/06.
**The most appropriate hearing instrument will be selected based on your needs. These discounts apply to all manufacturers, but the actual discount you receive will vary based on the manufacturer and the hearing aid.
A weight management discount program to look and feel better

Looking to lose weight and feel better? Our weight management discount program can help.

You and your eligible family members can save on weight-loss programs and products from one of the largest weight management firms worldwide — Jenny Craig®. You’ll get a sensible weight loss plan, one-on-one weekly consultations and discounts on weight loss products that fit your lifestyle.

You’ll start with a FREE 30-day membership. Then, join a program and save!

- Get 30%* off an OnTrack 6-month (Gold) or 12-month (Platinum) membership.
- Get 15%** off a Jenny Rewards 12-month membership.

You also get:

- Personalized menus
- Tailored activity planning
- Free unlimited use of Jenny Craig tools
- Flexible programs to fit your schedule
- And more

It’s easy to get started:

1. Enroll in an Aetna plan.
2. Register for your secure Aetna Navigator™ member website.
3. Print your personalized registration coupon.
4. Call 1-800-597-JENNY to find the centre nearest you.
5. Bring your registration coupon and Aetna ID to get your free consultation.

*Offers good only at participating centres and through Jenny Direct at-home. Additional cost for all food purchases. Discounts apply to membership fee only.

**Additional weekly food discounts will grow throughout the year, based on active participation.
More savings for you!

- Save on Sonicare® toothbrushes and Epic Dental products like gum, toothpastes, and mouth rinses with xylitol — a natural sweetener designed to stop tooth decay.
- Save 10% on gift certificates of $100 or more from SpaWish® that can be used at over 1,000 spas nationally.
- Subscribe to Zagat.com and get 30% off your membership. You'll get ratings on restaurants, hotels, movies, attractions and more.
- Get a personalized eating plan and save up to 25% on eDiets® membership dues.
- Save on newsletters or books from the MayoClinic.com bookstore.

Get fit, stay well and save!

What's more important than your health? Start saving today on services and products that can help you stay well. And take advantage of others that respond to your special needs.

They're the Aetna extras that are all here for you when you enroll in one of our medical benefits plans. Use them often. And use them in good health.
Important Disclosure Information: New Jersey

Plan of Benefits
Your plan of benefits will be determined by your plan sponsor. 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, including but not limited to, cosmetic surgery and experimental procedures. In addition, in order to be covered, all services, including the location (type of facility), duration and costs of services, must be medically necessary as defined below and as determined by Aetna. The information that follows provides general information regarding Aetna health plans. For a complete description of the benefits available to you, including procedures, exclusions and limitations, refer to your specific plan documents, which may include the Schedule of Benefits, Member Handbook and amendments to your plan.

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

Role of Primary Care Physicians (PCPs)
For most HMO plans, you are required to select a PCP who participates in the network. The PCP can 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 should 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 nonemergency specialty or hospital care. Check your plan documents for details.

Physician Board Certification
82% of Aetna's participating physicians are board certified. If you would like to know if a specific physician is board certified, or is currently accepting new patients, please call the Member Services number on your ID card.

Appointment Waiting Times
Aetna's standard for customary waiting times for PCP appointments for urgent care is 15 minutes or less, and 15 minutes for routine care.

Referral Policy
The following points are important to remember regarding referrals.
- The referral is how your PCP arranges for you to be covered for necessary, appropriate specialty care and follow-up treatment.
- You should discuss the referral with your PCP to understand what specialist services are being recommended and why.
- If the specialist recommends any additional treatments or tests that are covered benefits, you may need to get another referral from your PCP prior to receiving the services. If you do not get another referral for these services, you may be responsible for payment.
- Except in emergencies, all hospital admissions and outpatient surgery require a prior referral from your PCP and prior authorization by Aetna.
- If it is not an emergency and you go to a doctor or facility without a referral, you must pay the bill.
- Referrals are valid for 90 days as long as the individual seeking care remains an eligible member of the plan.
- In plans without out-of-network benefits, coverage for services from nonparticipating providers requires prior authorization by Aetna in addition to a special nonparticipating referral from the PCP. When properly authorized, these services are fully covered, less the applicable cost-sharing.
- The referral provides that, except for applicable cost sharing, you will not have to pay the charges for covered benefits, as long as the individual seeking care is a member at the time the services are provided.

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.

Mastectomy Coverage
Your coverage provides for a minimum of 72 hours of inpatient care following a modified radical mastectomy and a minimum of 48 hours of inpatient care following a simple mastectomy. A shorter stay is allowable if patient and patient's physician determine it is medically appropriate. The policy does not require a health care provider to obtain authorization from the insurer for prescribing the minimum 72 or 48 hours of inpatient care.
**Infertility Benefits**

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

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

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

*This mandate only applies to groups of 51 or more members.

**Health Care Provider Network**

All hospitals may not be considered participating for all services. Your physician can contact Aetna to identify a participating facility for your specific needs. Certain PCPs are affiliated with integrated delivery systems, independent practice associations (“IPAs”) or other provider groups, if you select these PCPs you will generally be referred to specialists and hospitals within that system, association or group. However, if your medical needs extend beyond the scope of the affiliated providers, you may request coverage for services provided by nonaffiliated network physicians and facilities. In order to be covered, services provided by nonaffiliated network providers may require prior authorization from Aetna and/or the integrated delivery systems or other provider groups. You should note that other health care providers (e.g. specialists) may be affiliated with other providers through systems, associations or groups. These systems, associations or groups (“organization”) or, their affiliated providers may be compensated by Aetna through a capitation arrangement or other global payment method. The organization then pays the treating provider directly through various methods.

You should ask your provider how he or she is being compensated for providing health care services to you and if he/she has any financial incentive to control costs.

**Transplants and Other Complex Conditions**

Our National Medical Excellence Program® and other specialty programs helps 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.

Note: There are exceptions depending on state requirements.

**Emergency Care**

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

Whether you are in or out of an Aetna service area, we simply ask that you follow the guidelines below when you believe you need emergency care.

- Call the local emergency hotline (ex. 911) or go to the nearest emergency facility. If a delay would not be detrimental to your health, call your PCP. Notify your PCP as soon as possible after receiving treatment.
- If you are admitted to an inpatient facility, you or a family member or friend on your behalf should notify your PCP of Aetna as soon as possible.

**Coverage for Children**

A child who does not reside with you or does not reside in the HMO Service Area is still eligible to enroll in your plan, provided the child complies with the terms and conditions of the plan with respect to the use of participating providers.

**What to Do Outside Your Aetna HMO 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 an emergency facility.

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.

If, after reviewing information submitted to us by the provider that supplied care, the nature of the urgent or 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.

**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.

**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 for a prescription drug. In addition, in circumstances where your prescription plan utilizes copayments or coinsurance calculated on a percentage basis or a deductible, your costs may be higher for a preferred drug than they would be for a nonpreferred drug. For information regarding how medications are reviewed and selected for the preferred drug list, please refer to Aetna’s website at www.aetna.com or the Aetna Preferred Drug (Formulary) Guide.
That it may receive from wholesalers, manufacturers, suppliers, and pharmacies. Discounts, credits, and other amounts are factored into the purchase process. Aetna Specialty Pharmacy incurs costs for purchasing drugs and providing specialty pharmacy services. The pharmacy might incur higher costs than Aetna Specialty Pharmacy. Healthcare, Inc. Aetna's negotiated charge with Aetna Rx Home Delivery is based on these costs. If you use the Aetna Specialty Pharmacy to fill a prescription, you are acquiring these prescriptions through an affiliate of Aetna. Terms and conditions apply. For more information, contact Member Services.

Prescription drugs may require precertification or step-therapy before they can be dispensed. Step-therapy is a form of preauthorization that requires approval before a medication is dispensed. Certain drugs may require these steps based on medical necessity. In some cases, a medication may be covered under specific conditions. Non-prescription drugs and drugs in the Limitations and Exclusions section are not covered and may not be subject to the same limitations.

New prescription drugs may also be subject to steps such as precertification or step-therapy. These new drugs may be covered under certain plans with an open formulary. New drugs may also be subject to step-therapy. Depending on the plan selected, new drug benefits may be available or subject to increased copayments or co-insurance. The plan documents outline these conditions.

Behavioral Health Network

Behavioral health care services are managed by Aetna, except for certain HMO-based health plans in New York that are managed by an independently contracted behavioral health organization. Aetna and the behavioral health care organization share responsibility for coverage determinations. You may appeal adverse behavioral health care coverage determinations in accordance with your health plan.

The type of behavioral health benefits available to you depends on the terms of your health plan. Behavioral health services may be covered for mental health conditions and drug or alcohol abuse services. You can determine the type of behavioral health coverage available under your plan by calling the Aetna Member Services number listed on your ID card.

In an emergency, call 911 or your local emergency hotline. For routine services, you may access covered behavioral health services through your plan. Step-therapy is a different form of precertification than the type of behavioral health care management used by the organization.

How Aetna Compensates Your Physician

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 or affiliating with a group or organization that contract with us. Participating providers in our network are compensated in various ways:

- 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.

Behavioral health network providers participate through a behavioral health organization. Aetna pays these organizations on a capitation basis. The organization reimburses the physician, provider organization, or facility on a fee for service or per diem basis for covered services.
One of the purposes of managed care is to manage the cost of health care. Incentives in compensation arrangements with physicians and health care providers are one method by which Aetna attempts to achieve this goal.

**Quality Enhancement**

In some regions, the PCP can receive additional compensation based upon performance on a variety of measures intended to evaluate the quality of care and services the PCP provides to you. This additional compensation is typically based on the scores received on one or more of the following measures of the PCP's office:

- Member satisfaction
- Percentage of members who visit the office at least annually
- Medical record reviews
- The burden of illness of the members that have selected the primary care physician
- Management of chronic illnesses like asthma, diabetes and congestive heart failure
- Whether the physician is accepting new patients
- Participation in Aetna's electronic claims and referral submission program.

Some regions may use some different measures designed to enhance physician performance or improve administrative efficiency. You are encouraged to ask your physicians and other providers how they are compensated for their services.

**Medically Necessary**

“Medically necessary” means that the service or supply is provided by a physician or other health care provider exercising prudent clinical judgment for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that provision of the service or supply is:

- In accordance with generally accepted standards of medical practice; and
- Clinically appropriate in accordance with generally accepted standards of medical practice in terms of type, frequency, extent, site and duration, and considered effective for the illness, injury or disease; and
- Not primarily for the convenience of you, or for the physician or other health care provider; and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the illness, injury or disease.

For these purposes “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

**Clinical Policy Bulletins (CPBs)**

Aetna's CPBs describe Aetna's policy determinations of whether certain services or supplies are medically necessary, based upon a review of currently available clinical information. Clinical determinations in connection with individual coverage decisions are made on a case-by-case basis consistent with applicable policies.

Aetna's CPBs do not constitute medical advice. Treating providers are solely responsible for medical advice and 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](http://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 your plan covers self-referred services to network providers, (i.e. Aetna Open Access), or out-of-network benefits and you may 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/Patient Management**

Aetna has developed a patient management program to assist in determining what health care services are covered under the health plan and the extent of such coverage. The program assists you in receiving appropriate health care and maximizing coverage for those health care services.

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

Concurrent Review

The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members receiving inpatient services. All inpatient services extending beyond the initial certification period will require concurrent review.

Discharge Planning

Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits to be utilized by you upon discharge from an inpatient stay.

Retrospective Record Review

The purpose of retrospective review is to retrospectively analyze potential quality and utilization issues, initiate appropriate follow-up action based on quality or utilization issues, and review all appeals of inpatient concurrent review decisions for coverage of healthcare services. Aetna’s effort to manage the services provided to you includes the retrospective review of claims submitted for payment, and of medical records submitted for potential quality and utilization concerns.

Complaints, Appeals and External Review

Filing a Complaint or Appeal

Note: This Complaint Appeal and External Review process may not apply if your plan is self-funded. Contact your Benefits Administrator if you have any questions.

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

If you are dissatisfied with the outcome of your initial contact, you may file an appeal. Your appeal will be decided in accordance with the procedures applicable to your plan and applicable state law. Refer to your plan documents for further details regarding your plan’s appeal procedure.

External Review

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

An Independent Review Organization (IRO) will assign the case to a physician reviewer with appropriate expertise in the area in question. After all necessary information is submitted, an external review generally will be decided within 30 calendar days of the request.

Expedited reviews are available when a physician certifies that a delay in service would jeopardize your health. Once the review is complete, the plan will abide by the decision of the external reviewer.

The cost for the review will be borne by Aetna (except where state law requires you to pay a filing fee as part of the state mandated program).

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

For further details regarding your plan’s appeal process and the availability of an external review process, call the Member Services toll-free number on your ID card or visit our website www.aetna.com where you may obtain an external review request form. You also may call your state insurance or health department or consult their website for additional information regarding state mandated external review procedures.

Independent Consumer Satisfaction Surveys

A member of the general public may request the results of independent consumer satisfaction results and an analysis of quality outcomes of health care services of managed care plans in the State of New Jersey. Copies of the guide may be obtained by calling 1-888-393-1062, or writing the Department of Health and Senior Services,* P.O. Box 360, Trenton, NJ 08625-0360. The guide may also be requested by e-mail at hmo@doh.state.nj.us. There is a fee for multiple copies. The guide is also available on the department’s web site at www.state.nj.us/health and may be viewed, printed or downloaded at no charge.

New Jersey QUITNET and New Jersey QUITLINE

Tobacco products pose a serious health threat in New Jersey, and cost the health insurance industry millions of dollars annually. The New Jersey Department of Health and Senior Services is providing two new free services that are available to consumers to help them kick the tobacco habit – the New Jersey Quitline (1-866-NJ-STOP5 or 1-866-657-8677) and the New Jersey Quitnet (www.nj.quitnet.com). The New Jersey Quitline provides individualized telephone-based counseling and referral programs for people who want to quit smoking and the New Jersey Quitnet offers personalized support and referrals online.

Member Rights

The “Member Rights” set forth pursuant to Regulations of the State of New Jersey provide that as a member you have the right to:

- Obtain a current directory of doctors participating within the network. Have access to a choice of participating specialists following a referral.

- Be referred to participating specialists who are experienced in treating your illness if you have a chronic illness.

* The functions of the former Managed Health Care Consumer Assistance Program (MHCCAP) are now being handled by Department of Health and Senior Services (DHSS).
- Have access to a primary care provider or a back-up 24 hours a day, 365 days a year for urgent care.
- Call 911 in a potentially life-threatening situation without prior approval from Aetna.
- Coverage for a medical screening exam in the emergency room to determine whether an emergency medical condition exists.
- Receive up to 4 months of continued coverage — if medically necessary — from a doctor who has been terminated by Aetna.
- Have a doctor make a utilization management denial of coverage.
- Have your physician discuss with you pertinent details regarding your condition. Doctors are encouraged to discuss all medical treatment options, the nature and purpose of any recommended procedure and the potential risk and benefits of any reasonable alternatives to such recommended treatment.
- Know how Aetna pays participating doctors, so you know if there are financial incentives or disincentives tied to satisfaction, quality of care, control of costs and the use of services.
- Appeal a utilization determination, first within Aetna and then through an independent organization for a $25 filing fee.
- Know you or your doctor cannot be penalized for filing a complaint or appeal.
- Know how providers in our networks for these products have agreed to be paid each time they treat you (fee-for-service).
- Receive prompt notification of termination or changes in benefits, services or provider network no more than 30 days following the date that the change is effective.
- File a complaint with Consumer Protection Services, Department of Banking and Insurance, 20 West State Street, 9th Floor, P.O. Box 329, Trenton, NJ 08625-0329; Main phone: 1-609-292-5316, Fax: 1-609-292-5865.

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.

We consider these activities key for the operation of our health plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

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The following information is provided to inform the member of certain provisions contained in the Group Health Plan, and related procedures that may be utilized by the member in accordance with federal law.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents’ other coverage).

However, you must request enrollment within 31 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact your benefits administrator.

Request for Certificate of Creditable Coverage

Members of insured plan sponsors and members of self insured plan sponsors who have contracted with us to provide Certificates of Prior Health Coverage have the option to request a certificate. This applies to terminated members, and it applies to members who are currently active but who would like a certificate to verify their status. Terminated members can request a certificate for up to 24 months following the date of their termination. Active member can request a certificate at any time. To request a Certificate of Prior Health Coverage, please contact Member Services at the telephone number on the back of your ID card.

Notice to Members

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

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna arranges for the provision of health care services. However, Aetna itself is not a provider of health care services and therefore, cannot guarantee any results or outcomes. Consult the plan documents [Group Agreement, Group Insurance Certificate, Schedule of Benefits, Certificate of Coverage, Group Policy] to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan. The availability of a plan or program may vary by geographic service area and by plan design. These plans contain exclusions and some benefits are subject to limitations or visit maximums.

With the exception of Aetna Rx Home Delivery®, all participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC. is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law. Certain primary care physicians are affiliated with integrated delivery systems or other provider groups (such as independent practice associations and physician-hospital organizations), and members who select these providers will generally be referred to specialists and hospitals within those systems or groups. However, if a system or group does not include a provider qualified to meet member's medical needs, member may request to have services provided by nonsystem or nongroup providers. Member’s request will be reviewed and will require prior authorization from the system or group and/or Aetna to be a covered benefit.

The NCQA Accreditation Seal is a recognized symbol of quality. NCQA recognition seals appear in the provider directory next to those providers who have been duly recognized. NCQA provider recognitions are subject to change.

For up-to-date information, please visit our DocFind® online provider directory at www.aetna.com or visit the NCQAs new top-level recognition listing at recognition.ncqa.org.

If you need this material translated into another language, please call Member Services at 1-888-982-3862.

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

†While this Member Notice is believed to be accurate as of the publication date, it is subject to change. Please contact the Member Services department if you have any questions.
This managed care plan may not cover all of your health care expenses. Read your member handbook carefully to determine which health care services are covered. To contact the plan if you are a member, call the number on your ID card; all others, call 1-888-98-AETNA (1-888-982-3862). This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna arranges for the provision of health care services. However, Aetna itself is not a provider of health care services, and therefore, cannot guarantee any results or outcomes. Consult the plan documents (e.g., Schedule of Benefits, Certificate of Coverage, Evidence of Coverage, Group Agreement) to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan. The availability of a plan or program may vary by geographic service area and by plan design. Health benefits plans contain exclusions and some benefits are subject to limitations or visit maximums. With the exception of Aetna Rx Home Delivery® service, all participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law. Not all topics discussed within the audio health service are covered expenses under your individual health benefits plan. While this material is believed to be accurate as of the print date, it is subject to change.

Aetna receives rebates from the manufacturers of many drugs, including many that are on the Preferred Drug List. These rebates do not reduce the amount you pay for an individual prescription drug. However, they help control the overall costs of prescription drug coverage. Also, in some cases, if you need to pay a percentage of the cost of the drug or an amount to meet a deductible, your costs may be higher for a “preferred drug” than they would be for a “non-preferred drug.” You can find out more about the terms and limitations on your plan by reading your plan documents. Aetna members can also contact Member Services.

Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna Inc., which is a licensed pharmacy that operates through mail order. Aetna Specialty Pharmacy refers to Aetna Specialty Pharmacy, LLC, which is jointly owned by Aetna and Priority Healthcare, Inc. Aetna Specialty Pharmacy is a licensed pharmacy that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery and Aetna Specialty Pharmacy may be higher than the cost those pharmacies pay for the drugs and the costs of their specialty pharmacy services. For these purposes, Aetna Specialty Pharmacy’s and Aetna Rx Home Delivery’s cost of purchasing drugs takes into account discounts, credits and other amounts that those pharmacies may receive from wholesalers, manufacturers, suppliers and distributors. While this material is believed to be accurate as of the print date, it is subject to change.

Alternative Health Care Programs, Aetna VisionSM Discounts, the Fitness Program and the Hearing Program are rate-access programs and may be in addition to any plan benefits. Program providers are solely responsible for the products and services provided thereunder. Aetna does not endorse any vendor, product or service associated with these programs. Discounts offered hereunder are not insurance. Aetna does not recommend the self-management of health problems, nor do we promote any particular form of medical treatment. You should consult your health care provider for the advice and care appropriate for your specific medical needs. Providers participating in these programs are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates.