Important Disclosure Information*

For Managed Choice®, Elect Choice®, Open Choice® and Aetna Open Access® Members.

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 Group Agreement, Group Insurance Certificate, Group Policy and any applicable riders and amendments to your plan.

Member Copays and Deductibles

Your plan of benefits may contain some or all of the following features:

- **Copayments or Coinsurance** - These are fees that you must pay for some covered medical expenses.
- **Calendar Year Deductible** - The amount of covered medical expenses you pay each calendar year before benefits are paid. There is a calendar year deductible that applies to each person.
- **Inpatient Hospital Deductible** - This is the amount of covered inpatient hospital expenses you pay for each hospital confinement.
- **Emergency Room Deductible** - A separate hospital emergency room deductible applies to each visit by a person to a hospital emergency room unless the person is admitted to the hospital as an inpatient within 24 hours after a visit to a hospital emergency room.

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

Role of Primary Care Physicians ("PCPs")

For some plans, members are required or encouraged to select a PCP who participates in the network. The PCP can provide primary care as well as coordinate your overall care. Members should consult their PCP when they are sick or injured to help determine the care that is needed. Under Elect Choice® EPO and Managed Choice® POS, your PCP should issue referrals to participating specialists and facilities for certain services.

For some services, the PCP is required to obtain prior authorization from Aetna. Under Elect Choice, except for those benefits described in the plan documents as direct access benefits or in an emergency, members will need to obtain a referral authorization ("referral") from their PCP before seeking covered nonemergency specialty or hospital care. Under Managed Choice POS, Open Choice® PPO and Aetna Open Access® Managed Choice you may go directly to a provider or facility for covered services, you will generally be responsible for a deductible and coinsurance in these circumstances. Even so, you may be able to reduce your out-of-pocket expenses considerably by using the participating providers listed in the Provider Directory. Additionally, under Aetna Open Access Managed Choice and Aetna Open Access Elect Choice you may go directly to a participating specialist without a referral from your PCP, and pay the applicable copay. Please refer to your plan documents for details.

Referral Policy

If your plan requires referrals to obtain maximum benefits, the following points are important to remember:

- The referral is how the member's PCP arranges for a member to be covered for necessary, appropriate specialty care and follow-up treatment.
- The member should discuss the referral with their PCP to understand what specialist services are being recommended and why.
- If the specialist recommends any additional treatments or tests that are covered services, the member may need to get another referral from their PCP prior to receiving the services. If the member does not get another referral for these services, the member may be responsible for payment.

** State mandates do not apply to self-funded plans. If you are unsure if your plan is self-funded, please confer with your benefits administrator. Specific plan documents supercede general disclosures contained within, as applicable.*

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

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- Except in emergencies, all hospital admissions and outpatient surgery require a prior referral from the member's PCP and prior approval by Aetna.
- If it is not an emergency and the member goes to a doctor or facility without a referral, the member must pay the bill.
- Referrals are valid for 60 days as long as the individual remains an eligible member of the plan
- Under Elect Choice, coverage for services from nonparticipating providers requires prior approval by Aetna in addition to a special nonparticipating referral from the PCP. When properly authorized, these services are fully covered, less the applicable copay.
- The referral provides that, except for an applicable copay, the member will not have to pay the charges for covered services, as long as the individual is a member at the time the services are provided.

If your plan does not specifically cover nonpreferred benefits and you go directly to a specialist or hospital for nonemergency or nonurgent care without a referral, you must pay the bill yourself unless the service is specifically identified as a direct access benefit in your plan documents.

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.

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, and members who select these PCPs 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.

Members 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. Members should ask their provider how that provider is being compensated for providing health care services to the member and if the provider has any financial incentive to control costs or utilization of health care services by the member.

Transplants and Other Complex Conditions

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

Emergency Care

If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world. An emergency medical condition 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 HMO service area, we simply ask that you follow the guidelines below when you believe you need emergency care.

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

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 a member pays 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. Printed Preferred Drug Guide information will be provided, upon request or if applicable, annually for current members and upon enrollment for new members. Additional information can be obtained by calling Member Services at the toll-free number listed on your member ID card. The medications listed on the preferred drug list are subject to change in accordance with applicable state law.

Your prescription drug benefit is generally not limited to drugs listed on the preferred drug list. Medications that are not listed on the preferred drug list (nonpreferred or nonformulary drugs) may be covered subject to the limits and exclusions set forth in your plan documents. Covered nonformulary prescription drugs may be subject to higher copayments or coinsurance under some benefit plans. Some prescription drug benefit plans may exclude from coverage certain nonformulary drugs that are not listed on the preferred drug list. If it is medically necessary for members enrolled in these benefit plans to use such drugs, their physicians (or pharmacist in the case of antibiotics and analgesics) may contact Aetna to request coverage as a medical exception. Check your plan documents for details.

In addition, certain drugs may require precertification or step-therapy before they will be covered under some prescription drug benefit plans. Step-therapy is a different form of precertification which requires a trial of one or more "prerequisite therapy" medications before a "step therapy" medication will be covered. If it is medically necessary for a member to use a medication subject to these requirements, the member's physician can request coverage of such drug as a medical exception. In addition, some benefit plans include a mandatory generic drug cost-sharing requirement. In these plans, you may be required to pay the difference in cost between a covered brand-name drug and its generic equivalent in addition to your copayment if you obtain the brand-name drug. Nonprescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received and/or available upon enrollment) are not covered, and medical exceptions are not available for them.

Depending on the plan selected, new prescription drugs not yet reviewed for possible addition to the preferred drug list are either available at the highest copay under plans with an "open" formulary, or excluded from coverage unless a medical exception is obtained under plans that use a "closed" formulary. These new drugs may also be subject to precertification or step-therapy.

Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding terms, conditions and limitations of coverage. If you use the mail order prescription program of Aetna Rx Home Delivery, LLC, you will be acquiring these prescriptions through an affiliate of Aetna. Aetna's negotiated charge with Aetna Rx Home Delivery® may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail-order pharmacy services. For these purposes, Aetna Rx Home Delivery's cost of purchasing drugs takes into account discounts, credits and other amounts that it may receive from wholesalers, manufacturers, suppliers and distributors.

If you use the Aetna Specialty Pharmacy specialty drug program, you will be acquiring these prescriptions through Aetna Specialty Pharmacy, LLC, which is jointly owned by Aetna and Priority Healthcare, Inc. Aetna's negotiated charge with Aetna Specialty Pharmacy may be higher than Aetna Specialty Pharmacy's cost of purchasing drugs and providing specialty pharmacy services. For these purposes, Aetna Specialty Pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that it may receive from wholesalers, manufacturers, suppliers and distributors.

Behavioral Health Network

If your plan through Aetna includes coverage for behavioral health care services, certain of these services are managed by an independently contracted behavioral health care organization. For example, the behavioral health care organization is responsible for, in part, making initial coverage determinations and coordinating referrals to members of the behavioral health care organization's provider network.

If your plan includes behavioral health care services, you can receive information regarding the appropriate way to access behavioral health care services that are covered under your specific plan by calling the Behavioral Health Vendor toll-free number on your ID card or, if there is not a

specific number listed, call the Member Services number on your ID card for the appropriate information. As with other coverage determinations, you may appeal adverse behavioral health care coverage determinations in accordance with the provisions of your health plan and/or applicable state law.

How Aetna Compensates Your Health Care Provider

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

Participating physicians, hospitals and other providers in our network are compensated in various ways for the services covered under your plan.

- Per individual service or case (fee for service at contracted rates).
- Per hospital day (per diem contracted rates).

Nonparticipating providers providing covered services are reimbursed on a fee-for-service basis. You are encouraged to ask your physicians and other providers how they are compensated for their services.

Claims Payment for Nonparticipating Providers and Use of Claims Software

If your plan provides coverage for services rendered by nonparticipating providers, you should be aware that Aetna determines the usual, customary and reasonable fee for a provider by referring to commercially available data reflecting the customary amount paid to most providers for a given service in that geographic area or by accessing other contractual arrangements. If such data is not commercially available, our determination may be based upon our own data or other sources. Aetna may also use computer software (including ClaimCheck®) and other tools to take into account factors such as the complexity, amount of time needed and manner of billing. You may be responsible for any charges Aetna determines are not covered under your plan.

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:

- Clinically appropriate in accordance with **generally accepted standards of medical practice** in term of type frequency, extent, site and duration,
- Considered effective in accordance with **generally accepted standards of medical practice** for the illness, injury or disease; and
- Not primarily for the convenience of the Member, 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.

"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. In the absence of such credible scientific evidence, the [Plan/HMO/Company's] determinations of whether a service or supply meets "generally accepted standards of medical practice" shall be consistent with physician specialty society recommendations and otherwise shall be based on 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 treatment of members. Members should discuss any CPB related to their coverage or condition with their 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. Members and their providers will need to consult the member's benefit plan to determine if there are any exclusions or other benefit limitations applicable to this service or supply.

CPBs are regularly updated and are therefore subject to change. Aetna's CPBs are available online at **www.aetna.com**.

Precertification

Precertification is the process of collecting information prior to inpatient admissions and performance of selected ambulatory procedures and services. The process permits advance determination of the medical necessity and appropriateness of the procedures and services from a coverage perspective, and communication with the physician and/or member. It also allows Aetna to coordinate the patient's transition from the inpatient setting to the next level of care (discharge planning), or to register patients for specialized programs like disease management, case management, or our prenatal program. 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 to obtain coverage for those services. When a member is to obtain services requiring precertification through a participating provider, this provider should precertify those services prior to treatment. If your plan covers out-of-network benefits and you may self-refer for covered services, it is your responsibility to contact Aetna to precertify those services which require precertification.

You must obtain precertification for certain types of care rendered by nonpreferred providers to avoid a reduction in benefits paid for that care. Refer to your plan documents for specific information. Only medically necessary services are covered. A service or supply furnished by a particular provider is medically necessary if Aetna determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

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 members in receiving appropriate healthcare and maximizing coverage for those healthcare 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 integrated delivery systems, independent practice associations or other provider groups ("Delegates"), such Delegates utilize criteria that they deem appropriate. Utilization review/patient management policies may be modified to comply with applicable state law.

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

Concurrent Review

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

Discharge Planning

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

Retrospective Record Review

The purpose of retrospective review is to retrospectively analyze potential quality and utilization issues, initiate appropriate follow-up action based on quality or utilization issues, and review all appeals of inpatient concurrent review decisions for coverage of health care services. Aetna's effort to manage the services provided to members 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

Aetna is committed to addressing members' 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. If you are not satisfied after filing a formal appeal, you may request a second level appeal of the decision. Your appeal will be decided in accordance with the procedures applicable to your plan and applicable state law. Refer to your plan documents for further details regarding your plan's appeal procedure.

*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.

External Review
Aetna established an external review process to give eligible members the opportunity of requesting an objective and timely independent review of certain coverage denials. Once the applicable appeal process has been exhausted, eligible members may request an external review of the decision if the coverage denial, for which the member 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 treatment. 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 member's physician certifies that a delay in service would jeopardize the member's 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 members 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.

Confidentiality and Privacy Notices

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third-party administrators, vendors, consultants, government authorities, and their respective agents.

These parties are required to keep personal information confidential as provided by applicable law. Participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claims payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, and disease and case management; quality assessment and improvement activities; auditing and antifraud activities; performance measurement and outcomes assessment; health claims analysis and reporting; health services research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a 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.

State Variations*

In some states, Aetna provides additional consumer disclosures in documents also posted on our website at www.aetna.com.

Colorado

To obtain reimbursement rates for nonparticipating providers, members may contact Member Services at the number on their ID card.

Colorado law requires Aetna to make available a Colorado Health Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within 3 business days to a potential policyholder who has expressed interest in a particular plan. Aetna also must provide the form, upon oral or written request, within 3 business days, to any person who is interested in coverage under or who is covered by a health benefits plan of Aetna.

The Colorado Consumer Protection Standards Act for the operation of Managed Care Plans ((S)10-16-704(9) of the Colorado Revised Statutes), requires a carrier to maintain an "access plan" for each managed care network that the carrier offers in Colorado. In general, an access plan lists hospitals, providers, referral procedures, grievance procedures, and emergency coverage provisions.

The law requires the carrier to make its access plans (except for certain confidential information, as specified in section 24-72-204 (3) of the Colorado Revised Statutes) available on its business premises and to provide them to any interested party upon request. To obtain additional information regarding our Colorado access plan(s), please call Member Services at the toll-free number shown on the member's ID card.

Enrolling in Aetna does not guarantee services by a particular provider on this list. If you wish to be sure of receiving care from specific providers listed, you should contact those providers to be sure that they are accepting additional patients for Aetna. Also, we may add physicians on a periodic basis and will provide you with a listing of newly added doctors in your local area, if you request it.

The availability of any particular provider cannot be guaranteed for referred or in-network benefits, and provider network composition is subject to change without notice. In addition, not every provider listed in the directory will be accepting new patients. For the most current information, please contact the selected physician or Member Services at the toll-free number on your ID card.

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

In accordance with Colorado law, Aetna has established open enrollment periods for guarantee issue basic or standard plan applications from business groups of one.

The open enrollment period is a period of 31 days following the birth date of the person qualifying as a business group of one. Issuance of a basic health benefit plan and a standard health benefit plan is limited to such thirty-one day period. A copy of the applicant's driver's license or birth certificate must be provided as evidence of the applicant's birth date. In addition to the annual 31 day enrollment period, persons qualifying as business groups of one may apply within 31 days of the date of the following events: (1) the end of state or federal continuation coverage; (2) the person initially meets the business group of one definition requirements and whose birth date is more than 31 days after doing so; or (3) the person involuntarily loses other creditable coverage. (This event (3) does not apply in cases of failure to pay premium, fraud, or a voluntary decision on the part of the person to terminate other creditable coverage.

Renewability

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

- Nonpayment of premiums;
- Fraud or intentional misrepresentation of material fact on the part of the plan sponsor with respect to group health benefit plan coverage and the individual with respect to individual coverage;

*State benefits mandates may not apply to self-insured plans. Contact Member Services with specific questions about your coverage.

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

Provider Network

In Colorado, Aetna's complete network for the products listed on the cover of the provider directory include providers only in the following counties:

Adams, Arapahoe, Broomfield, Boulder, Clear Creek, Denver, Douglas, Elbert, El Paso, Gilpin, Jefferson, Larimer, Mesa, Pueblo, Teller, Weld

There are no participating providers at the time of printing in counties other than the ones listed above.

Delaware

For plans that require or encourage members to select a PCP, female members may choose a participating obstetrician/gynecologist (Ob/Gyn) as their PCP if:

- the Ob/Gyn meets the standards established by the plan for PCPs,
- the Ob/Gyn requests that the plan make the Ob/Gyn available for designation as a PCP,
- the Ob/Gyn agrees to accept the payment terms applicable under the Plan to PCPs for services other than Ob/Gyn services,
- the Ob/Gyn agrees to abide by all other terms and conditions applicable to PCPs under the plan generally. If the female member does not choose a participating Ob/Gyn as her primary then the member must be permitted to visit the participating Ob/Gyn without referral for covered services. In such cases, the Ob/Gyn must consult with the PCP with respect to the care given and any follow up care, and the plan may require a visit to the PCP, if necessary, before the patient may be directed to another specialty provider, or for inpatient hospitalization or outpatient surgical procedures.

Georgia

Members can call toll-free at 1-800-223-6857 to confirm that the preferred provider in question is in the network and/or accepting new patients.

Members have direct access to the participating primary Ob/Gyn provider of their choice and do not need a referral from their PCP for a routine well-woman exam, including a Pap smear when appropriate and an unlimited number of visits for gynecologic problems and follow-up care.

Members also have direct access to the participating dermatologist provider of their choice and do not need a referral from their primary care physicians to access dermatologic benefits covered under their health plan.

A summary of any agreement or contract between Aetna and any health care provider will be made available upon request by calling the Member Services telephone number on your ID card. The summary will not include financial agreements as to actual rates, reimbursements, charges, or fees negotiated by Aetna and the provider. The summary will include a category or type of compensation paid by Aetna to each class of health care provider under contract with Aetna.

Consumer Choice Option

The Consumer Choice Option is available for Georgia residents enrolled in certain Aetna managed care plans.

Under this benefit option, with certain restrictions required by law and an additional monthly premium cost, members of certain Aetna managed care plans may nominate an out-of-network provider to provide covered services for themselves and their covered family members. Your benefits and any applicable copayments will be the same as for in-network providers. The out-of-network provider must agree to accept the Aetna compensation, to adhere to the plan's quality assurance requirements, and to meet all other reasonable criteria required by the plan of its in-network participating providers. It is possible the provider you nominate will not agree to participate.

This option is available for an increased premium in addition to the premium you would otherwise pay. Your increased premium responsibility will vary depending on whether you have a single plan or family coverage, and on the type of insurance, riders, and coverage. Exact pricing and any additional information can be obtained by calling 1-800-433-6917. Please have your Aetna member ID card available when you call.

Hawaii

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

Your provider will:

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

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

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

Illinois

While every provider listed in the provider directory contracts with Aetna to provide primary care services, not every provider listed will be accepting new patients. Although Aetna has identified those providers who were not accepting patients as known to Aetna at the time the Provider Directory was created, the status of the physician's practice may have changed. For the most current information regarding the status of any physician's practice, please contact either the selected physician or call Member Services at the toll-free number on your ID card.

Illinois law requires health plans to provide the following information annually to enrollees and to prospective enrollees upon request: a complete list of participating health care providers in the health care plan's service area and a description of the following terms of coverage:

1. The service area;
2. The covered benefits and services with all exclusions, exceptions and limitations;
3. The pre-certification and other utilization review procedures and requirements;
4. A description of the process for the selection of a PCP, any limitation on access to specialists, and the plan's standing referral policy;
5. The emergency coverage and benefits, including any restrictions on emergency care services;
6. The out-of-area coverage and benefits, if any;
7. The enrollee's financial responsibility for copayments, deductibles, premiums, and any other out-of-pocket expenses;
8. The provisions for continuity of treatment in the event a health care provider's participation terminates during the course of an enrollee's treatment by the provider;
9. The appeals process, forms, and time frames for health care services appeals, complaints, and external independent reviews, administrative complaints, and utilization review complaints, including a phone number to call to receive more information from the health care plan concerning the appeals process; and
10. A statement of all basic health care services and all specific benefits and services to be provided to enrollees by a State law or administrative rule.

Additionally, upon written request, the health plan will provide enrollees with a description of the financial relationship between the health plan and any health care provider, including, if requested, the percentage of copayments, deductibles, and total premiums spent on health care related expenses and the percentage of copayments, deductibles and total premiums spent on other expenses, including administrative expenses.

Kansas

Kansas law permits you to have the following information upon request:

1. a complete description of the health care services, items and other benefits to which the insured is entitled in the particular health plan which is covering or being offered to such person;
2. a description of any limitations, exceptions or exclusions to coverage in the health benefit plan, including prior authorization policies, restricted drug formularies or other provisions which restrict access to covered services or items by the insured;
3. a listing of the plan's participating providers, their business addresses and telephone numbers, their availability, and any limitation on an insured's choice of provider;
4. notification in advance of any changes in the health benefit plan which either reduces the coverage or benefits or increases the cost to such person; and
5. a description of the grievance and appeal procedures available under the health benefit plan and an insured's rights regarding termination, disenrollment, nonrenewal or cancellation of coverage.

Kentucky

Any provider who meets our enrollment criteria and who is willing to meet the terms and conditions for participation has a right to become a participating provider in our network.

Managed Choice POS plan members have direct access to the participating primary chiropractic provider of their choice and do not need a referral from their primary care physician to access chiropractic benefits covered under their health benefit plan.

Customary Waiting Times

Routine-	Within 7 days
Preventive Care-	Within 4 weeks
Symptomatic, Nonurgent-	Within 3 days
Follow-up Visit-	Within 2 weeks
Urgent Complaint-	Same Day/within 24 hours
Emergency-	Immediately or referred to ER

Emergency Medical Condition Definition

A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson would reasonably have cause to believe constitutes a condition that the absence of immediate medical attention could reasonably be expected to result in: placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, a situation in which there is inadequate time to effect a safe transfer to another hospital before delivery; or a situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.

Louisiana

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

Maryland

Experimental Medical Treatment

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

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

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

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

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

or

Maryland Insurance Administration
Life and Health Insurance Complaints
525 Saint Paul Place
Baltimore, Maryland 21202-2272
Telephone: 1-800 492-6116 (toll-free)

or

Phone: 410-468-2244
Facsimile: 410-468-2243

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

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

or

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

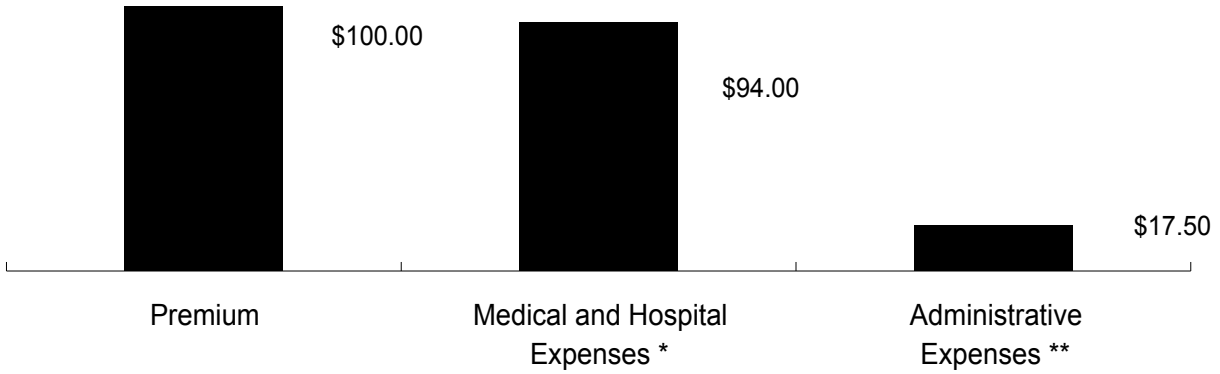
Nothing herein shall be construed to require Aetna Health Inc. to pay counsel fees or any other fees or costs incurred by a member in pursuing a complaint or appeal.

Our compensation to physicians who offer health care services to our insured members or enrollees may be based on a variety of payment mechanisms such as fee-for-service payments discounted fee-for-service payments, or capitation. Bonuses may be used with these various types of payment methods.

If you desire additional information about methods of paying physicians or if you want to know which method(s) apply to your physician, please call Aetna Life Insurance Company at 1-(410) 691-1080 or write us at: 1301 McCormick Drive, Largo, MD 20774.

Terms	The example shows how Dr. Jones, an obstetrician gynecologist, would be compensated under each method of payment.	Percent of Physicians Paid Using this Described Method
Salary	A physician is an employee of Aetna and is paid compensation (monetary wages) for providing specific health care services. Since Dr. Jones is an employee of Aetna, she receives her usual bi-weekly salary regardless of how many patients she sees or the number of services she provides. During the months of providing prenatal care to Mrs. Smith, who is a member of Aetna, Dr. Jones' salary is unchanged. Although Mrs. Smith's baby is delivered by Cesarean section, a more complicated procedure than a vaginal delivery, the method of delivery will not have any effect upon Dr. Jones' salary.	0%
Capitation	A physician (or group of physicians) is paid a fixed amount of money per month by Aetna for each patient who chooses the physician(s) to be his or her doctor. Payment is fixed without regard to the volume of services that an individual patient requires. Under this type of contractual arrangement, Dr. Jones participates in an Aetna network. She is not employed by Aetna. Her contract with Aetna stipulates that she is paid a certain amount each month for patients who select her as their doctor. Since Mrs. Smith is a member of Aetna, Dr. Jones' monthly payment does not change as a result of her providing ongoing care to Mrs. Smith. The capitation amount paid to Dr. Jones is the same whether or not Mrs. Smith requires obstetric services.	30%
Fee-for-Service	A physician charges a fee for each patient visit, medical procedure, or medical service provided. An Aetna pays the entire fee for physicians it has under contract and an insurer pays all or part of that fee, depending on the type of coverage. The patient is expected to pay the remainder. Dr. Jones' contract with the insurer or Aetna states that Dr. Jones will be paid a fee for each patient visit and each service she provides. The amount of payment Dr. Jones receives will depend upon the number, types, and complexity of services, and the time she spends providing services to Mrs. Smith. Because Cesarean deliveries are more complicated than vaginal deliveries, Dr. Jones is paid more to deliver Mrs. Smith's baby than she would be paid for a vaginal delivery. Mrs. Smith may be responsible for paying some portion of Dr. Jones' bill.	70%
Discounted Fee-for-Service	Payment is less than the rate usually received by the physician for each patient visit, medical procedure, or service. This arrangement is the result of an agreement between the payer, who gets lower costs and the physician, who usually gets an increased volume of patients. Like fee-for-service, this type of contractual arrangement involves the insurer or HMO paying Dr. Jones for each patient visit and each delivery; but, under this arrangement, the rate, agreed upon in advance, is less than Dr. Jones' usual fee. Dr. Jones expects that in exchange for agreeing to accept a reduced rate, she will serve a certain number of patients. For each procedure that she performs, Dr. Jones will be paid a discounted rate by the insurer or Aetna.	77%
Bonus	A physician is paid an additional amount over what he or she is paid under salary, capitation, fee-for-service, or other type of payment arrangement. Bonuses may be based on many factors, including member satisfaction, quality of care, control of costs and use of services. An Aetna rewards its physician staff or contracted physicians who have demonstrated higher than average quality and productivity. Because Dr. Jones has delivered so many babies and she has been rated highly by her patients and fellow physicians, Dr. Jones will receive a monetary award in addition to her usual payment.	0%
Case Rate	Aetna or insurer and the physician agree in advance that payment will cover a combination of services provided by both the physician and hospital for an episode of care. This type of arrangement stipulates how much an insurer or Aetna will pay for a patient's obstetric services. All office visits for prenatal and postnatal care, as well as the delivery, and hospital-related charges are covered by one fee. Dr. Jones, the hospital, and other providers (such as an anesthesiologist) will divide payment from the insurer or HMO for the care provided to Mrs. Smith.	0%

PREMIUM DOLLAR DISTRIBUTION DISCLOSURE



The cost of providing health care services in the State of Maryland exceeded the premium revenue per $100.

* Medical and Hospital Expenses includes the costs of physician services, other professional services, referrals, emergency room visits, hospitalization and pharmacy.

** Administrative Expenses include, but may not be limited to: occupancy, depreciation and amortization, marketing, salaries, interest expense and accounting and corporate expenses.

Michigan

Contact the Michigan Department of Consumer and Industry Services at 1-517-373-0220 to verify participating providers' licenses or to access information on formal complaints and disciplinary actions filed or taken against participating providers.

Upon request, pursuant to Michigan law, the following information can be supplied to you:

1. date of provider certification by applicable nationally recognized board or other organization;
2. names of licensed facilities where providers have privileges;
3. prior authorization requirements and limitations including medication formulary restrictions;
4. information about financial relationships between providers and the health plan.

Intractable Pain Coverage

Aetna provides benefits for the evaluation and treatment of intractable pain when it is determined to be medically necessary and otherwise eligible by Aetna. Intractable pain means "a pain state in which the cause of the pain cannot be removed or otherwise treated and which, in the generally accepted practice of allopathic or osteopathic medicine, no relief of the cause of the pain or cure of the cause of the pain is possible or none has been found after reasonable efforts, including, but not limited to, evaluation by the attending physician and by 1 or more other physicians specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain."

To obtain this and further information on the health plan you may call Member Services at 1-800-208-8755 or write to Aetna Health Inc., 26957 Northwestern Highway, Suite 140, Southfield, MI 43034-4728.

Nevada

Precertification

Precertification is the process of collecting information prior to inpatient admissions and performance of selected ambulatory procedures and services. The process permits advance determination of the medical necessity and appropriateness of the procedures and services from a coverage perspective, and communication with the physician and/or member. It also allows Aetna to coordinate the patient's transition from the inpatient setting to the next level of care (discharge planning), or to register patients for specialized programs like disease management, case management, or our prenatal program. 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 to obtain coverage for those services. When a member is to obtain services requiring precertification through a participating provider, this provider should precertify those services prior to treatment. If your plan covers out-of-network benefits and you may self-refer for covered services, it is your responsibility to contact Aetna to precertify those services which require precertification to avoid a reduction in benefits paid for that service.

New Jersey

Managed Health Care Consumer Assistance Program
In New Jersey, the functions of the former Managed Health Care Consumer Assistance Program (MHCCAP), as discussed in the Disclosure Information, are now being handled by Department of Health and Senior Services (DHSS). To contact the DHSS for information or assistance call toll-free **1-888-393-1062**.

Infertility Benefits (This mandate only applies to groups of 51 or more members):
New Jersey mandates certain infertility benefits. Your employer as permitted by law can elect not to provide coverage for the following procedures because they conflict with their bona fide religious tenets:

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

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

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

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 primary care physician appointments for urgent care is 15 minutes or less, and 15 minutes for routine care.

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.
- 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 New Jersey Department of Health and Senior Services, P.O. Box 360, Trenton, NJ 08625-0360, 1-888-393-1062, *in New Jersey*, 609-633-0660, or New Jersey Department of Insurance and Banking Division of Insurance Enforcement and Consumer Complaints, P.O. Box 329, Trenton, NJ 08625-0329, 1-800-446-7467, *in New Jersey*, 609-292-5316.

New York

New York Legislation mandates that group insurance policies and contracts which provide coverage for prescription drugs must include a rider providing coverage for contraceptive drugs and devices that are approved by the FDA or generics approved as substitutes by the FDA. However, "Religious Employers", as defined in the law, may elect not to include this coverage under their policy or contract. If a Religious Employer elects not to provide coverage for contraceptives, each insured/enrollee covered under the contact is eligible to obtain a contraceptive rider directly from Aetna.

Disclosure of Information

Each insurer subject to this article shall supply each insured, and upon request each prospective insured prior to enrollment, written disclosure information, which may be incorporated into the insurance contract or certificate, containing at least the information set forth below. In the event of any inconsistency between any separate written disclosure statement and the insurance contract or certificate, the terms of the insurance contract or certificate shall be controlling. The information to be disclosed shall include at least the following:

1. a description of coverage provisions; health care benefits; benefit maximums, including benefit limitations; and exclusions of coverage, including the definition of medical necessity used in determining whether benefits will be covered;
2. a description of all prior authorization or other requirements for treatments and services;
3. a description of utilization review policies and procedures, used by the insurer, including: the circumstances under which utilization review will be undertaken; the toll-free telephone number of the utilization review agent; the timeframes under which utilization review decisions must be made for prospective, retrospective and concurrent decisions; the right to reconsideration, the right to an appeal, including the expedited and standard appeals processes and the timeframes for such appeals; the right to designate a representative; and a notice that all denials of claims will be made by qualified clinical personnel and that all notices of denials will include information about the basis of the decision and further appeal rights, if any;
4. a description prepared annually of the types of methodologies the insurer uses to reimburse providers specifying the type of methodology that is used to reimburse particular types of providers or reimburse for the provision of particular types of services, provided, however, that nothing in this paragraph should be construed to require disclosure of individual contracts or the specific details of any financial arrangement between an insurer and a health care provider;
5. an explanation of an insured's financial responsibility for payment of premiums, coinsurance, copayments, deductibles and any other charges, annual limits on an insured's financial responsibility, caps on payments for covered services and financial responsibility for noncovered health care procedures, treatments or services;
6. an explanation, where applicable, of an insured's financial responsibility for payment when services are provided by a health care provider who is not part of the insurer's network of providers or by any provider without required authorization, or when a procedure, treatment or service is not a covered benefit;
7. a description of the grievance procedures to be used to resolve disputes between an insurer and an insured, including: the right to file a grievance regarding any dispute between an insured and an insurer; the right to file a grievance orally when the dispute is about referrals or covered benefits; the toll-free telephone number which insureds may use to file an oral grievance; the timeframes and circumstances for expedited and standard grievances; the right to appeal a grievance determination and the procedures for filing such an appeal; the timeframes and circumstances for expedited and standard appeals; the right to designate a representative; a notice that all disputes involving clinical decisions will be made by qualified clinical personnel and that all notices of determination will include information about the basis of the decision and further appeal rights, if any;
8. a description of the procedure for obtaining emergency services. Such description shall include a definition of emergency services, notice that emergency services are not subject to prior approval, and shall describe the insured's financial and other responsibilities regarding obtaining such services including when such services are received outside the insurer's service area, if any;
9. where applicable, a description of procedures for insureds to select and access the insurer's primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients;

10. where applicable, a description of the procedures for changing primary and specialty care providers within the insurer's network of providers;
11. where applicable, notice that an insured enrolled in a managed care product offered by the insurer may obtain a referral to a health care provider outside of the insurer's network or panel when the insurer does not have a health care provider with appropriate training and experience in the network or panel to meet the particular health care needs of the insured and the procedure by which the insured can obtain such referral;
12. where applicable, notice that an insured enrolled in a managed care product offered by the insurer with a condition which requires ongoing care from a specialist may request a standing referral to such a specialist and the procedure for requesting and obtaining such a standing referral;
13. where applicable, notice that an insured enrolled in a managed care product offered by the insurer with (i) a life-threatening condition or disease, or (ii) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request a specialist responsible for providing or coordinating the insured's medical care and the procedure for requesting and obtaining such a specialist;
14. where applicable, notice that an insured enrolled in a managed care product offered by the insurer with (i) a life-threatening condition or disease, or (ii) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request access to a specialty care center and the procedure by which such access may be obtained;
15. a description of how the insurer addresses the needs of non-English speaking insureds;
16. notice of all appropriate mailing addresses and telephone numbers to be utilized by insureds seeking information or authorization; and;
17. where applicable, a listing by specialty, which may be in a separate document that is updated annually, of the name, address, and telephone number of all participating providers, including facilities, and in addition, in the case of physicians, board certification.

Each insurer subject to this article, upon request of an insured, or prospective insured, shall:

1. provide a list of the names, business addresses and official positions of the membership of the board of directors, officers, and members of the insurer;
2. provide a copy of the most recent annual certified financial statement of the insurer, including a balance sheet and summary of receipts and disbursements prepared by a certified public accountant;
3. provide a copy of the most recent individual, direct pay subscriber contracts;
4. provide information relating to consumer complaints compiled pursuant to applicable New York insurance law;
5. provide the procedures for protecting the confidentiality of medical records and other insured information;
6. where applicable, allow insureds and prospective insureds to inspect drug formularies used by such insurer; and provided further, that the insurer shall also disclose whether individual drugs are included or excluded from coverage to an insured or prospective insured who requests this information;
7. provide a written description of the organizational arrangements and ongoing procedures of the insurer's quality assurance program, if any;
8. provide a description of the procedures followed by the insurer in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials;
9. provide individual health practitioner affiliations with participating hospitals, if any;
10. upon written request, provide specific written clinical review criteria relating to a particular condition or disease and, where appropriate, other clinical information which the insurer might consider in its utilization review and the insurer may include with the information a description of how it will be used in the utilization review process; provided, however, that to the extent such information is proprietary to the insurer, the insured or prospective insured shall only use the information for the purposes of assisting the enrollee or prospective enrollee in evaluating the covered services provided by the organization;
11. disclose such other information as required by the superintendent, provided that such requirements are promulgated pursuant to the state administrative procedure act.

Provider Information

For information about a provider licensed by New York State, you may call the office of Professional Medical Conduct (under the auspices of the New York Department of Health) at 1-800-663-6114.

North Carolina

Direct Access Gynecology Program
Any female member 13 years or older may visit any participating gynecologist for a routine well-woman exam, including a Pap smear when appropriate and an unlimited number of visits for gynecologic problems and follow-up care.

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

Ohio

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

Pennsylvania

This managed care plan may not cover all your health care expenses. Read your plan documents 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 1-800-323-9930.

RHODE ISLAND

HB 8167 / SB 2814 -
Mandated Benefit / Women's Health
Your Aetna health plan provides benefits for mastectomy and mastectomy-related services, including reconstruction and surgery to achieve symmetry between breasts; prosthesis; and treatment of physical complications of all stages of mastectomy, including lymph edemas.

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

Texas

Please refer to the plan design overview and summary of riders contained in your pre-enrollment packet for a brief description of the services and benefits covered under your particular plan, as well as those services and benefits that are excluded. After enrollment, you can refer to your plan documents for a more complete description of your covered services and benefits and the exclusions under your plan. For information on whether a specific service is covered or excluded, please contact Member Services at the toll-free number on your ID card.

In Texas precertification is known as "preservice utilization review" and is not "verification" as defined by Texas Law.

Utah

Choosing an Ob/Gyn as PCP
If your plan requires you to select a PCP to receive optimum coverage, you may select an obstetrician/gynecologist who has qualified as a primary care provider, as your provider from whom primary care services can be obtained.

Virginia

Important Information Regarding Your Insurance
In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance or if you have additional questions, you may contact the insurance company issuing this insurance at the following address and telephone number.

Aetna Health Inc.
P.O. Box 31450
Tampa, FL 33631-3450
1-800-843-5869

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

Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Phone: 1-804-371-9691
Fax: 1-804-371-9944

or

You may contact the Office of the Managed Care Ombudsman at:

Office of the Managed Care Ombudsman
Bureau of Insurance
PO Box 1157
Richmond, VA 23218
Toll Free: 1-877-310-6560
Richmond Metropolitan Area: 804-371-9032

Ombudsman@scc.state.va.us

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

Aetna Life Insurance Company is regulated as a Managed Care Health Insurance Plan (MCHIP) and as such, is subject to regulation by both the Virginia State Corporation Commission Bureau of Insurance and the Virginia Department of Health.

Washington State

Listing of Other Primary Care Providers

Under Washington State Law, you may select a participating Advanced Registered Nurse Practitioner (ARNP) in our provider network to be your primary care provider. ARNPs are licensed registered nurses who have been prepared in a formal educational program to assume an expanded role in providing health care services. ARNPs are qualified to assume primary responsibility for the care of their patients. ARNPs may also prescribe drugs according to applicable state and federal laws. ARNPs will work together with a participating provider if hospital care is necessary. ARNPs must also meet Aetna's standards to be primary care providers and must pass a stringent certification and recertification process. Under Washington law, female members may self-refer to "women's health care specialists", including physicians, ARNP nurse midwives, ARNPs and PAs who specialize in women's health care for women's health care services including maternity.

Managed care coverage is provided by Aetna Health of Washington Inc. and Aetna Health Inc.

The following materials are available: any documents referred to in the enrollment agreement; preauthorization procedures; physician compensation arrangements and descriptions of and justification for provider compensation programs; description of the formulary, if any; circumstances under which the plan may retrospectively deny coverage previously authorized.*

**This is a state mandate which may apply to self-insured plans.*

Health Insurance Portability and Accountability Act Member Notice*

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.

Pre-existing Conditions Exclusion Provision (only for plans containing such provision)

This is to advise you that a pre-existing conditions exclusion period may apply to you, if a pre-existing conditions exclusion provision is included in the Group Plan that you are or become covered under. If your plan contains pre-existing conditions exclusion, such exclusion may be waived for you if you have prior Creditable Coverage.

Note: If a state law mandates a gap period greater than 90 days, that longer gap period will be used to determine creditable coverage.

If you have any questions regarding the determination of whether or not pre-existing conditions exclusion applies to you, please call the Member Services telephone number on your ID card.

Creditable Coverage

Creditable coverage includes coverage under a group health plan (including a governmental or church plan), health insurance coverage (either group or individual insurance), Medicare, Medicaid, military-sponsored health care (TRICARE) a program of the Indian Health Service, a State health benefit risk pool, the FEHBP, a public health plan as defined in the regulations, and any health benefit plan under section 5(c) of the Peace Corps Act. Not included as creditable coverage is any coverage that is exempt from the law (e.g., dental only coverage or dental coverage that is provided in a separate plan or even if in the same plan as medical, is separately elected and results in additional premium).

If you had **prior creditable coverage** within the 90 days immediately before the date you enrolled under this plan, then the pre-existing conditions exclusion in your plan, if any, will be **waived**. The determination of the 90 day period will not include any waiting period that may be imposed by your employer before you are eligible for coverage.

If you had **no prior creditable coverage** within the 90 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 90 day gap from the date your prior coverage terminated to your enrollment date), we will **apply** your plan's pre-existing conditions exclusion (to a maximum period of 12 months).

Providing Proof of Creditable Coverage

Generally, you will have received a **certification of prior health coverage** from your prior medical plan as proof of your prior coverage. You should retain that certification until you submit a medical claim. When a claim for treatment of a potential pre-existing condition is received, the claim office will request from you that **certification of prior health coverage**, which will be used to determine if you have creditable coverage at that time.

You may request a **certification of prior health coverage** from your prior carrier(s) with whom you had coverage within the past two years. Our Service Center can assist you with this and can provide you with the type of information that you will need to request from your prior carrier. The Service Center may also request information from you regarding any pre-existing condition for which you may have been treated in the past, and other information that will allow them to determine if you have creditable coverage.

Special Enrollment Periods

Due to Loss of Coverage

If you are eligible for coverage under your employer's medical plan but do/did not enroll in that medical plan because you had other medical coverage, and you lose that other medical coverage, you will be allowed to enroll in the current medical plan during special enrollment periods after your initial eligibility period, if certain conditions are met. These special enrollment rules apply to employees and/or dependents who are eligible, but not enrolled for coverage, under the terms of the plan.

* 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.

An employee or dependent is eligible to enroll during a special enrollment period if each of the following conditions are met:

- When you declined enrollment for you or your dependent, you stated in writing that coverage under another group health plan or other health insurance was the reason for declining enrollment, if the employer required such written notice and you were given notice of the requirement and the consequences of not providing the statement; and
- When you declined enrollment for you or your dependent, you or your dependent had COBRA continuation coverage under another plan and that COBRA continuation coverage has since been exhausted; or
- If the other coverage that applied to you or your dependent when enrollment was declined was not under a COBRA continuation provision, either the other coverage has been terminated as a result of the loss of eligibility or employer contributions toward that coverage have been terminated. Loss of eligibility includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, or reduction in hours of employment.

For Certain Dependent Beneficiaries

If your Group Health Plan offers dependent coverage, it is required to offer a dependent special enrollment period for persons becoming a dependent through marriage, birth, or adoption or placement for adoption. The dependent special enrollment period will last for 31 days from the date of the marriage, birth, adoption or placement for adoption. The dependent may be enrolled during that time as a dependent of the employee. If the employee is eligible for enrollment, but not enrolled, the employee may also enroll at this time. In the case of the birth or adoption of a child, the spouse of the individual also may be enrolled as a dependent of the employee if the spouse is otherwise eligible for coverage but not already enrolled. If an employee seeks to enroll a dependent during the special enrollment period, the coverage would become effective as of the date of birth, of adoption or placement for adoption, or marriage.

Special Enrollment Rules

To qualify for the special enrollment, individuals who meet the above requirements must submit a signed request for enrollment no later than 31 days after one of the events described above. The effective date of coverage for individuals who lost coverage will be the date of the qualifying event. If you seek to enroll a dependent during the special enrollment period, coverage for your dependent (and for you, if also enrolling) will become effective as of the date that the qualifying event occurred, (for marriage, as of the enrollment date) once the completed request for enrollment is received.

As of 7/1/2005 this addendum replaces the Health Insurance Portability and Accountability Act Member Notice that appears elsewhere in this disclosure. See your Benefit Summary for information regarding preexisting conditions exclusions.

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.

*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.

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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, 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.

For up-to-date information, please visit our DocFind® online provider directory at **www.aetna.com**.

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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.

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