



Aetna Advantage Plans for Individuals and Families Important Disclosure Information Pennsylvania

HMO and Aetna Open AccessTM Members

This managed care plan may not cover all of your health care expenses. Read your contract 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 1-800-435-8742.

Coverage Description

Benefits are provided for many of the services and supplies needed for care and treatment of sickness and injuries or to maintain good health. Not all services and supplies are covered, some are covered only to a limited extent and some require precertification and referrals.

Some of the services and supplies for which benefits are provided include:

- Primary care physician (PCP) visits.
- Periodic health evaluations, including: well child care and immunizations; routine physical examinations.
- Injections, including allergy desensitization injections.
- Casts and dressings.
- Diagnostic, laboratory, and x-ray services.
- Specialist physician visits, including outpatient and inpatient services.
- Direct access specialists visits for routine gynecological visits and for diagnosis and treatment of gynecological problems.
- Maternity care and related newborn care.
- Inpatient hospital and skilled nursing facility care.
- Nonexperimental transplants.
- Outpatient surgery.

- Substance abuse care (inpatient/outpatient services for detoxification).
- Emergency care/urgent care.
- Physical, occupational and speech therapy.
- Home health and hospice care.
- Prosthetic appliances.
- Reconstructive breast surgery following mastectomy.

Services and supplies that are generally not covered include, but are not limited to:

- Cosmetic surgery, including breast reduction.
- Special duty nursing unless medically necessary and preauthorized by Aetna.
- Blood and blood byproducts.
- Experimental and investigational procedures.
- Immunization for travel or work.
- Orthotics.
- Long-term rehabilitation therapy.
- Services for the treatment of sexual dysfunction or inadequacies including, therapy, supplies, counseling or prescription drugs.
- Home births.

- Implantable drugs and certain injectible drugs including injectible infertility drugs.
- Reversal of sterilization.
- Infertility services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services.
- Donor egg retrieval.
- Radial keratotomy or related procedures.
- Treatment for behavioral disorders.
- Therapy or rehabilitation other than those listed as covered.
- Nonmedically necessary services and supplies.

To be medically necessary, the service or supply must:

- Be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the member's overall health condition.
- Be care or services related to diagnosis or treatment of an existing illness or injury, except for covered periodic health evaluations and preventive and well baby care, as determined by Aetna.
- Be a diagnostic procedure, indicated by the health status of the member and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the member's overall health condition.
- Include only those services and supplies that cannot be safely and satisfactorily provided at home, in a physician's office, on an outpatient basis, or in any facility other than a hospital, when used in relation to inpatient hospital services.
- As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests.

In determining if a service or supply is medically necessary, Aetna patient management medical director or its physician designee will consider:

- Information provided on the member's health status.
- Reports in peer reviewed medical literature.

- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data.
- Professional standards of safety and effectiveness, which are generally recognized in the United States for diagnosis, care or treatment.
- The opinion of health professionals in the generally recognized health specialty involved.
- The opinion of the attending physicians, which have credence but do not overrule contrary opinions.
- Any other relevant information brought to Aetna's attention.

The issuance of a prior written referral in accordance with the Aetna policies and procedures by the member's PCP, or other physician providing service at the direction of the PCP, shall constitute proof of medical necessity for the purposes of determining a member's potential liability.

Referral Policy

The following points are important regarding referrals:

- 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 treatment or tests that are covered benefits, 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.
- Female members may visit any participating gynecologist for a routine well-woman exam, including a Pap smear, and for gynecological problems without a referral from their PCP. Gynecologists may also refer a woman directly to other participating providers for covered gynecologic services.
- Except in emergencies, all hospital admissions and outpatient surgery require a prior referral from the member's PCP and precertification by Aetna Health.
- 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 90 days as long as the individual remains an eligible member of the plan.

- Coverage for services from nonparticipating providers requires precertification by Aetna in addition to a special nonparticipating referral from the PCP. When properly authorized, these services are fully covered, less the applicable copayment.
- The referral provides that, except for applicable copayments, the member will not have to pay the charges for covered benefits, as long as the individual is a member at the time the services are provided.

Direct Access

Under Aetna Open Access plans a member may directly access participating providers without a PCP referral, subject to the terms and conditions of the plan and cost sharing requirements.

Participating providers will be responsible for obtaining any required preauthorization of services from Aetna. Refer to your specific plan brochure for details.

Precertification

Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the services requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the member's PCP is coordination care, the PCP will obtain the precertification. When the member self-refers to a nonparticipating provider, member must obtain precertification. Member should refer to their plan document for a complete list of medical services that require precertification.

*Preexisting Conditions

During the first 12 months following a member's effective date of coverage, no coverage will be provided for the treatment of a preexisting condition. A preexisting condition is an illness or injury for which, during the 6 month period immediately prior to the date the member first becomes covered for which medical advice, diagnosis, care, or treatment was recommended or received.

The preexisting condition limitation does not apply to pregnancy or to a newborn, an adopted child under age 19 or a child placed for adoption under age 19, if the child becomes covered under Creditable Coverage within 31 days of birth, adoption, or placement of adoption.

Aetna waives this preexisting condition limitation provision if, under a prior group or individual health benefits plan, there has been a significant break in coverage for not more than 63 consecutive day period, except that neither a waiting period or an affiliation period is taken into account in determining a significant break in coverage. The preexisting condition limitation period will be reduced by the number of days of prior creditable coverage the member has of the effective date of coverage.

***Aetna Advantage Plans for Individuals and Families is medically underwritten. Approval for coverage is based on Aetna underwriting.**

Member Cost Sharing

Members 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 plan documents.

If your plan has a maximum limit, your cost for covered benefits made by or on behalf of a member shall not exceed the maximum out-of-pocket limit, during the contract year. You may submit for a refund of your covered benefits costs that exceed the maximum out-of-pocket limit

Non-English speaking Members

Aetna Member Services has a Spanish-speaking hotline - 1-800-533-6615. Also available is a Multilingual hotline - 1-800-323-9930 (140 languages are available. You must ask for an interpreter.)

Aetna Provider Directory includes an Index of Providers Speaking Additional Languages sorted alphabetically by language spoken.

Mailing Address and Telephone Number

If a member needs to contact Aetna to obtain approval or authorization of a health care service, the member can write to Aetna Health Inc., 980 Jolly Road, P.O. Box 1109, Blue Bell, Pennsylvania 19422 or call the toll-free Member Services number on the ID card.

Members can also contact Member Services by going to Aetna Navigator™, Aetna self-service website, at www.aetna.com (click on Aetna Navigator in the "Quick Tools" drop down box).

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 health care and maximizing coverage for those healthcare services.

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.

Where such use is appropriate, our utilization review/patient management staff uses nationally recognized guidelines and resources, such as Milliman Care Guidelines™ and InterQual® ISD® criteria, to guide the precertification, concurrent review and retrospective review process. 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.

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 and payment of healthcare 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

This Complaints, Appeals and External Review Process may not apply if your plan is self-funded. Contact your Benefits Administrator if you have any questions.

Complaints Process

Our complaints process is designed to address member 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. If Member Services is unable to resolve your issue, complaint or problem to your satisfaction, you can request that your concern be forwarded to the regional grievance unit or you may write to:

Mid-Atlantic Regional Grievance Unit
2201 Renaissance Blvd.
P.O. Box 61517
King of Prussia, PA 19406-0916

You have the right to designate a representative to file complaints and appeals on your behalf. You can also contact Member Services through the Internet at www.aetna.com or at the toll-free number on your ID card for more information. A representative will address your concern. If you are dissatisfied with the outcome of your initial contact, you may file a complaint with our Grievance Unit. If you are not satisfied after filing a formal complaint, you may appeal the decision. Your appeal will be decided in accordance with the procedures applicable to your plan and applicable state laws. All disputes involving denial of payment for a health care service will involve a licensed physician or where appropriate a licensed psychologist, in the same or similar specialty that typically manages or consults on the health care service in question. Refer to your plan documents for further details regarding your plan’s complaint procedures.

External Review

Aetna developed an external review process to give members the added option of requesting an objective and timely external review of certain coverage denials. Once the Aetna internal coverage decision review process is exhausted, eligible members may elect external review of the decision if the coverage denial, for which the member would be financially responsible, involves more than \$500 (or the applicable dollar amount specified by your state), and is based on lack of medical necessity or on the experimental or investigational nature of the proposed service or treatment.

An external review organization will refer the case to review by an independent physician 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.

Emergency Care

Medical Emergency is defined as the existence of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; (2) serious impairment of bodily functions; or (3) serious dysfunction of any bodily organ or part.

You are covered for emergency services 24 hours a day, anywhere in the world, provided the service is a covered benefit and is medically necessary. In an emergency, it is not necessary to call your PCP or Aetna prior to receiving care. Aetna covers emergency care screening and stabilization for conditions that reasonably appear to constitute an emergency, based on your presenting symptoms. Also covered is emergency transportation and related emergency services provided by a licensed ambulance service. Prior authorization is not required for emergency medical care.

You will be reimbursed for the cost of emergency services rendered by a non-participating provider located either within or outside the service area, for those expensed, less copayments, which are incurred up to the time the member is determined by Aetna and the attending physician to be medically able to travel or to be transported to a participating provider. In the event that transportation is medically necessary, the member will be reimbursed for the cost as determined by Aetna Health, less any applicable copayments. Reimbursement may be subject to payment by the member of all copayments which would have been required had similar benefits been provided during office hours and upon prior referral to a participating provider.

On occasion you may need nonemergency care after office hours. Your PCP is on call 24 hours a day, 365 days a year, and is available after regular office hours, either through an answering service or through another physician who is taking patient calls. In urgent care situations, you should call your PCP for instructions before seeking medical care. Your PCP may advise you to seek emergency room care, direct you to an urgent care facility, or advise you that care can wait until regular office hours.

Provider Directories - Using DocFind® to Locate Providers

DocFind — It's available to anyone, anytime, any day.

Anyone who visits the Aetna website (www.aetna.com) find DocFind by using the Quick Tools feature, or by entering Aetna member website, Navigator. Once in DocFind, visitors can search for any type of provider in our database—physicians, dentists, facilities and vendors, hospitals, Vision One® providers, behavioral health providers, pharmacies, natural alternatives providers and other health care professionals. DocFind's data is refreshed three times a week to provide the latest information available about our network of participating providers and health care professionals.

A direct link to Aetna Navigator lets a member change PCPs or request a new member ID card:

https://www.aetna.com/Member_Public/index.jsp

DocFind displays additional information about participating providers (where available), including whether they are board certified, what medical school they attended, what year they graduated and if they are accepting new patients. DocFind also displays other office locations in which a provider may see members. These details about each provider do not appear in printed directories but are available on DocFind.

Though DocFind contains the most current information available, should you want to obtain a copy of our paper directory, please call the toll-free Member Services number on your ID Card or send a secure message to Member Services from Aetna Navigator.

Life-Threatening Conditions

Any member 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 that a specialist or specialty care center assume responsibility for providing or coordinating the member's medical care, including primary and specialty care. A member may make this request through the member's selected PCP. If Aetna Health, or the PCP, in consultation with a medical director of Aetna and specialist, if any, determines that the member's care would most appropriately be coordinated by such a specialist or specialty care center, Aetna will authorize a referral to the specialist or specialty care center.

Aetna is not required to permit a member to elect to have a nonparticipating specialist, unless such a specialist is not available within Aetna network of participating providers. Any authorized referral shall be made pursuant to a treatment plan approved by Aetna in consultation with the PCP (if appropriate), the specialist or specialty care center, the member or the member's designee. The approved specialist or specialty care center will be permitted to treat the member without a referral from the member's PCP and may authorize referrals, procedures, tests and other medical services as the member's PCP would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan. If the member's referral is to a nonparticipating provider, services provided pursuant to the approved treatment plan will be provided at no extra cost to the member beyond what the member would otherwise pay for services received within the Aetna network of participating providers.

For the purposes of this provision, a specialty care center means only centers that are accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

Continuity of Care

If a member's health care provider stops participation with Aetna for reasons other than imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board that impairs the health professional's ability to practice, Aetna will continue coverage for the member to continue an ongoing course of treatment with the member's current health care provider during a transitional period.

Coverage shall continue for up to 90 days from the date of notice to the member of the provider's termination of participation with Aetna or if the member has entered the second trimester of pregnancy, for a transitional period that includes the provision of postpartum care directly related to the delivery. The coverage will be authorized by Aetna for the transitional period only if the health care provider agrees to accept reimbursement at the rates applicable prior to the start of transitional period as payment in full; to adhere to quality standards and to provide medical information related to such care; and to adhere to Aetna policies and procedures. This paragraph shall not be construed to require Aetna to provide coverage for benefits not otherwise covered.

For new members, coverage will be provided for new members to continue an ongoing course of treatment with member's current health care provider for a transitional period of up to 60 days from the effective date of enrollment. If the member has entered the second trimester of pregnancy as of the effective date of enrollment, the transitional period shall include the provision of postpartum care directly related to the delivery. The coverage will be authorized by Aetna for the transitional period only if the health care provider agrees to accept reimbursement rates established by Aetna as payment in full; to adhere to Aetna quality standards and to provide medical information related to the care; and to adhere to Aetna policies and procedures. This paragraph shall not be construed to require Aetna to provide coverage for benefits not otherwise covered.

Board of Directors or Officers

You can obtain a list of the names, business addresses and official positions of the membership of the board of directors or officers by writing to Aetna Health Inc., 980 Jolly Rd., P.O. Box 1109, Blue Bell, Pennsylvania 19422.

Physician Credentials

Before physicians are accepted into Aetna network, they are reviewed for licensure and other credentials, quality of care and office standards. Besides their initial review, participating PCPs are also re-reviewed on a regular basis.

Prescription Drugs

The following applies if your plan provides outpatient prescription drug coverage through an Aetna pharmacy network.

Pharmacies are reimbursed based upon a combination of the following payment methodologies.

Discount from Average Wholesale Price: Pharmacy receives an agreed upon percentage discount from the Average Wholesale Price of the pharmaceutical product dispensed.

Fee Schedule: Pharmacy is paid a fee established by Aetna for each pharmaceutical product dispensed.

Professional Dispensing Fee: Pharmacy is paid a professional fee as agreed upon by Pharmacy and Aetna for each pharmaceutical product dispensed.

Where the member is responsible for a copayment or coinsurance calculated on a percentage basis, the member's obligation is to be determined on the basis of Aetna's negotiated payment rate with the pharmacy, if any, rather than on the basis of the pharmacy's billed charges. Such negotiated pharmacy payment rate does not include any rebates Aetna may receive from drug manufacturers.

Any charge for a service or supply furnished by a network pharmacy in excess of such provider's negotiated payment rate for that service or supply will not be a covered expense under your plan. In no event will you be expected to pay any such excess charge. It will be the responsibility of Aetna and the network pharmacy to resolve the amount deemed to be excess.

Your plan may include a drug formulary. A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan subject to applicable limitations and conditions. The medications listed on the formulary are subject to change in accordance with applicable state law. In evaluating clinically and therapeutically similar drugs for selection for the formulary, Aetna reviews the costs of drugs and takes into account rebates negotiated between Aetna and drug manufacturers. Consequently, a drug may be included on the formulary that is more expensive than a non-formulary alternative before any rebates Aetna may receive from a drug manufacturer are taken into account. In addition, certain drugs may be chosen for formulary status because of their clinical or therapeutic advantages or level of acceptance among physicians even though they cost more than non-formulary alternatives.

For additional information regarding how medications are reviewed and selected for the formulary, please refer to the Aetna Medication Formulary Guide. A printed copy of the Formulary Guide will be provided, upon request or if applicable, annually for current members and upon enrollment for new members. Additional copies can be obtained by calling Member Services at the toll-free number listed on your member ID card and current Formulary Guide information is available by accessing our website at www.aetna.com.

Many drugs listed on the formulary are subject to manufacturer rebate arrangements between Aetna and the manufacturer of the drugs. Your pharmacy benefit is not limited to the drugs listed on the formulary. Medications that are not listed on the formulary may be covered subject to the limits and exclusions set forth in your plan documents. Covered prescription drugs not listed on the formulary may be subject to higher copayments under some benefit plans. In prescription plans with copayment or coinsurance tiers, use of formulary drugs generally will result in lower costs to members. However, where the prescription plan utilizes copayments or coinsurance calculated on a percentage basis, there could be some circumstances in which a formulary drug would cost the member more than a non-formulary drug because (i) the negotiated pharmacy payment rate for the formulary drug may be more than the negotiated pharmacy payment rate for the non-formulary drug, and (ii) rebates received by Aetna from drug manufacturers are not reflected in the cost of a prescription drug obtained by a member.

Some pharmacy benefit plans may exclude certain drugs not listed on the formulary from coverage. If it is medically necessary for members enrolled in these benefit plans to use such drugs, their physicians (or pharmacist in the case of antibiotics and analgesics) may contact Aetna to request coverage as a medical exception. Aetna will respond to complete medical exception requests within 24 hours of receipt. You may be required to pay the difference in cost between a covered brand-name drug and its generic equivalent in addition to your copayment, depending on the benefit plan selected by your plan sponsor. Check your plan documents for details. In addition, certain drugs may require precertification or step therapy under some prescription drug benefit plans. Step therapy is a different form of precertification which requires a trial of one or more "prerequisite therapy" medications before a "step therapy" medication will be covered. If it is medically necessary for a member to use a medication subject to these requirements, the member's physician can request coverage of such drug as a medical exception. Aetna will respond to complete medical exception requests within 24 hours of receipt. Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and conditions of coverage.

Clinical Policy Bulletins

Aetna's Clinical Policy Bulletins (CPBs) are used as a guide when determining health care coverage for our members. CPBs are written on selected clinical issues, especially addressing new technologies, new treatment approaches, and procedures. CPBs are based on peer-reviewed medical literature, the recommendations of leading medical organizations, and (where appropriate) the Centers for Medicare & Medicaid Services' Medicare coverage policies. Some CPBs are available online at www.aetna.com. Because CPBs can be highly technical and are designed to be used by our professional staff making coverage determinations, members may want to review the CPBs of interest with their physician so they may fully understand them. CPBs do not constitute medical advice and treating providers are solely responsible for medical advice and treatment of members. Aetna makes actual coverage decisions on a case-by-case basis. The CPB is used as a tool to be interpreted in conjunction with the member's specific benefit plan and after consultation with the treating physician. CPBs are subject to change.

Experimental Procedures

A drug, medical device, procedure or treatment will be determined to be experimental if:

- There is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- Required FDA approval has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or
- The written protocol or protocols used by the treating facility or the protocol or protocols of any other facility studying substantially the same drug, medical device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, medical device, procedure or treatment states that it is experimental or for research purposes; or
- It is not of proven benefit for the specific diagnosis or treatment of a member's particular condition; or
- It is not generally recognized by the medical community as effective or appropriate for the specific diagnosis or treatment of a member's particular condition; or

- It is provided or performed in special settings for research purposes.

How Aetna Compensates Your Physician

All the physicians in the directory are independent practicing physicians that are neither employed nor exclusively contracted with Aetna Health. 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 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 reimburse the physician or facility directly for services by a variety of methods. In such arrangements, the group or organization has a financial incentive to control the cost of care.

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.

PCPs who participate in Aetna receive incentives as part of the QE program.

You are encouraged to ask your physicians and other providers how they are compensated for their services.

Quality Enhancement:

The Quality Enhancement rewards PCPs for their scores on several measures intended to evaluate the quality of care and services the PCPs provide to members. PCP offices can earn additional compensation for each member each month 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, and participation in Aetna electronic claims and referral submission program.

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. If such data is not commercially available, our determination may be based upon our own data. Aetna may also use computer software (including ClaimCheck) and other tools to take into account factors such as the complexity, amount of time needed and manner of billing. You may be responsible for any charges Aetna determines are not covered under your plan.

Quality Assurance Program

Aetna has developed a comprehensive Quality Improvement Program that places strict attention on quality measurement and improvement and is designed to identify and respond to the health care concerns of our members. Some of our quality-focused initiatives include:

- routine monitoring of quality of service and care, including:
- the performance of medical chart review audits in the office setting to evaluate the quality of preventive care.
- medical director review of member utilization patterns to determine prevalence of acute and chronic conditions, and the need for focused disease management programs,
- comprehensive utilization management and case management programs,
- review of survey results which assess member and provider satisfaction level, and

- periodic analysis of provider availability and access.
- rigorous provider certification and recertification, as well as quality performance-based physician and facility contracting.
- adoption and use of practice guidelines, including preventive care recommendations.
- Health promotion and wellness programs which proactively seek to identify members who may be considered high-risk, and which offer incentives to members who participate and achieve predetermined goals in fitness, smoking-cessation, and weight-loss programs.
- The use of an automated tracking system to monitor member complaints and grievance, which help, identify opportunities to improve service levels.
- Programs to monitor and address potential underutilization, and denial or delay in providing needed services.
- Measuring provider performance to improve the quality of care, assessing medical costs to improve the value of care, and delivering sophisticated and integrated data reporting products to customers.
- Annual evaluation of the Quality Improvement Program, including voluntary review and accreditation by the National Committee for Quality Assurance (NCQA), an independent, not-for-profit organization dedicated to assessing and reporting on the quality of care and service delivered by managed care organizations.

Confidentiality

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

When necessary or appropriate for your care or treatment, the operation of our health plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. Participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

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

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

Health Insurance Portability and Accountability Act Member Notice*

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

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 (CHAMPUS), 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 63 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 63 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 63 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 63-day gap from the date your prior coverage terminated to your enrollment date), we will **apply** your plan's preexisting conditions exclusion (to a maximum period of 12 months).

Please Note: If a state law mandates a gap period greater than 63 days, that longer gap period will be used to determine creditable coverage. If you have any questions regarding the determination of whether or not a preexisting conditions exclusion applies to you, please call the Member Services telephone number on your ID card.

Providing Proof of Creditable Coverage

Generally, you will have received a **Certification Of Prior Group Health Plan 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 Group Health Plan Coverage**, which will be used to determine if you have creditable coverage at that time. You may request a Certification Of Prior Group Health Plan 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.

* 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.



Notice to Members

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

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee any results or outcomes. Consult the plan documents [Group Insurance Certificate, Booklet, Booklet-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. 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 providers are affiliated with integrated delivery systems or other provider groups (such as independent practice associations and physician-hospital organizations), and members who select these providers will generally be referred to specialists and hospitals within those systems or groups. However, if a system or group does not include a provider qualified to meet member's medical needs, member may request to have services provided by 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.

Plans are provided by Aetna Health Inc., and/or Corporate Health Insurance Company.