HEALTH CARE INSURER APPEALS PROCESS INFORMATION PACKET
AETNA HEALTH INC./AETNA HEALTH INSURANCE COMPANY

PLEASE READ THIS NOTICE CAREFULLY AND KEEP IT FOR FUTURE REFERENCE. IT CONTAINS IMPORTANT INFORMATION ABOUT HOW TO APPEAL DECISIONS WE MAKE ABOUT YOUR HEALTH CARE COVERAGE.

Getting Information about the Health Care Appeals Process

Help in Filing an Appeal: Standardized Forms and Consumer Assistance from the Department of Insurance

We must send you a copy of this information packet when you first receive your policy, and within 5 business days after we receive your request for an appeal. When your insurance coverage is renewed, we must also send you a separate statement to remind you that you can request another copy of this packet. We will also send a copy of this packet to you or your treating provider at any time upon request. To request a copy, just call the Member Services number printed on your Member ID Card.

At the back of this packet, you will find forms you can use for your appeal. The Arizona Insurance Department ("the Department") developed these forms to help people who want to file a health care appeal. You are not required to use them. We cannot reject your appeal if you do not use them. If you need help in filing an appeal, or you have questions about the appeals process, you may call the Department's Consumer Assistance Office at 1-602-364-2499 (within Phoenix) or 1-800-325-2548 (outside Phoenix), or you may call us at 1-800-756-7039.

How to Know When You Can Appeal

When we do not authorize or approve a service or pay for a claim, we must notify you of your right to appeal that decision. Your notice may come directly from us, or through your treating provider.

Decisions You Can Appeal

You can appeal the following decisions:

1. We do not approve a service that you or your treating provider has requested.
2. We do not pay for a service that you have already received.
3. We do not authorize a service or pay for a claim because we say that it is not "medically necessary."
4. We do not authorize a service or pay for a claim because we say that it is not covered under your insurance policy, and you believe it is covered.
5. We do not notify you, within 10 business days of receiving your request, whether or not we will authorize a requested service.
6. We do not authorize a referral to a specialist.

Decisions You Cannot Appeal

You cannot appeal the following decisions:

1. You disagree with our decision as to the amount of "usual, customary, and reasonable charges." Where applicable, a usual, customary, and reasonable charge is a charge for a covered benefit which is determined by us to be the prevailing charge level made for the service or supply in the geographic area where it is furnished. We may take into account factors such as the complexity, degree of skill needed, type or specialty of the provider, range of services provided by a facility, and the prevailing charge in other areas in determining the usual, customary, and reasonable charge for a service or supply that is unusual or is not often provided in the area or is provided by only a small number of providers in the area.
2. You disagree with how we are coordinating benefits when you have health insurance with more than one insurer.
3. You disagree with how we have applied your claims or services to your plan deductible.
4. You disagree with the amount of coinsurance or copayments that you paid.
5. You disagree with our decision to issue or not issue a policy to you.

6. You are dissatisfied with any rate increases you may receive under your insurance policy.
7. You believe we have violated any other parts of the Arizona Insurance Code.

If you disagree with a decision that cannot be appealed according to this list, you may still file a complaint with us by calling our Customer Services Department at the number printed on your Member ID Card. In addition, you may also file such complaints with the Arizona Department of Insurance, Consumer Affairs Division, 2910 N. 44th Street, Second Floor, Phoenix, AZ 85018.

Who Can File an Appeal

Either you or your treating provider can file an appeal on your behalf. At the end of this packet is a form that you may use for filing your appeal. You are not required to use this form. If you wish, you can send us a letter with the same information. If you decide to appeal our decision to deny authorization for a service, you should tell your treating provider so the provider can help you with the information you need to present your case.

DESCRIPTION OF THE APPEALS PROCESS

I. Levels of Review

We offer expedited as well as standard appeals for Arizona residents. Expedited appeals are for urgently needed services that you have not yet received. Standard appeals are for non-urgent service requests and denied claims for services already provided. Both types of appeals follow a similar process, except that we process expedited appeals much faster because of the patient's condition.

Each type of appeal has three levels, as follows:

	Expedited Appeals (For urgently needed services you have not yet received)	Standard Appeals (For non-urgent services or denied claims)
Level One:	Expedited Medical Review	Informal Reconsideration
Level Two:	Expedited Appeal	Formal Appeal
Level Three:	Expedited External, Independent Medical Review	External, Independent Medical Review

We make the decisions at Level One and Level Two. An outside reviewer, who is completely independent from our company, makes Level Three decisions. You are not responsible to pay the costs of the external review if you choose to appeal to Level Three. These three levels of Appeals are discussed more fully below:

EXPEDITED APPEAL PROCESS FOR URGENTLY NEEDED SERVICES NOT YET PROVIDED

Expedited Medical Review (Level One)

Your Request: You may obtain Expedited Medical Review of your denied request for a service that has not already been provided if:

- You have coverage with us;
- We denied your request for a covered service; and
- Your treating provider certifies that the time required to process your request through the Informal Reconsideration (Level One) and Formal Appeal (Level Two) appeal process (about 30 days) is likely to cause a significant negative change in your medical condition. (At the end of this packet is a form that your provider may use for this purpose. Your provider could also send a letter or make up a form with similar information.) Your treating provider must send the certification and documentation to:

Name:	Aetna Health Inc./Aetna Health Insurance Company
Title:	National Clinical Appeals Unit
Address National Accounts:	P.O. Box 14001, Lexington, KY 40512
Address Regional Businesses:	P.O. Box 14002, Lexington, KY 40512
Phone:	1-877-665-6736
Fax:	1-860-754-5321

Our Decision: We must call and inform you and your treating provider of our decision within **1 business day or 36 hours from request receipt, whichever is less.** We will then mail our decision in writing to both you and your treating provider. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request: You may immediately appeal to Level Two.

If we grant your request: We will authorize the service and the appeal process is complete.

If we refer your case to Level Three: We may decide to skip Level One and Level Two and send your case straight to an independent reviewer at Level Three.

Expedited Appeal (Level Two)

Your request: If we deny your request at Level One, you may request an Expedited Appeal. After you receive our Level One denial, your treating provider ***must immediately*** send us a request (to the same person and address listed above under Level One) to tell us you are appealing to Level Two. To help your appeal, your provider should also send us any more information that the provider hasn't already sent us to show why you need the requested service.

Our Decision: We must call and inform you and your treating provider of our decision within **1 business day or 36 hours from request receipt, whichever is less.** We will then mail our decision in writing to both you and your treating provider. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request : You may immediately appeal to Level Three.

If we grant your request: We will authorize the service and the appeal process is complete.

If we refer your case to Level Three: We may decide to skip Level Two and send your case straight to an independent reviewer at Level Three.

Expedited External, Independent Review (Level Three)

Your request: The Member may Appeal to Expedited External Independent Medical Review only after the Member has appealed through Level Two. The Member has 5 business days after the Member receives Aetna Level Two decision to send Aetna the Member's written request for Expedited External Independent Medical Review. The Member's request should include any additional information to support the Member's request for the service.

Name:	Priscilla Bugari, R.N.
Title:	Director, Aetna National External Review Unit
Address:	11675 Great Oaks Way, Alpharetta, GA 30022
Phone:	1-877-848-5855 (Toll-free number)
Fax:	1-770-346-1087

The Member and the Member's treating Provider are not responsible for the cost of any Expedited External Independent Medical Review.

Process:

There are 2 types of Expedited External Independent Medical Review Appeals, depending on the issues in the Member's case:

1. Medical Necessity Appeals are cases where Aetna has decided not to authorize a service because Aetna believes the service(s) the Member or the Member's treating Provider are asking for, are not Medically Necessary to treat the Member's condition. The expedited external independent reviewer is a Provider retained by an outside independent review organization ("IRO"), that is procured by the Arizona Insurance Department, and not connected with Aetna. The IRO Provider must be a Provider who typically manages the condition under review.

   Within 1 business day of receiving the Member's request, Aetna must:

   - Mail a written acknowledgement of the request to the Director of Insurance, the Member, and the Member's treating Provider.
   - Send the Director of Insurance: the request for review; the Member's Certificate of Coverage or Group Insurance Certificate; all medical records and supporting documentation used to render Aetna decision; a summary of the applicable issues including a statement of Aetna decision; the criteria used and clinical reasons for Aetna decision; and the relevant portions of Aetna utilization review guidelines. Aetna must also include the name and credentials of the Provider who reviewed and upheld the denial at the earlier appeal levels.

Within 2 business days of receiving Aetna information, the Director of Insurance must send all the submitted information to an expedited, external independent reviewer organization (the "IRO").

Within 5 business days of receiving the information, the IRO must make a decision and send the decision to the Insurance Director.

Within 1 business day of receiving the IRO's decision, the Insurance Director must mail a notice of the decision to Aetna, the Member, and the Member's treating Provider.

2. Contract Coverage issues are Appeals where Aetna has denied coverage because Aetna believes the requested service is not covered under the Member's Aetna Certificate of Coverage. For these Appeals, the Arizona Insurance Department is the expedited external independent reviewer.

   Within 1 business day of receiving the Member's request, Aetna must:

   - Mail a written acknowledgement of the Member's request to the Insurance Director, the Member, and the Member's treating Provider.
   - Send the Director of Insurance: the request for review, the Member's Aetna Certificate of Coverage or Group Insurance Certificate; all medical records and supporting documentation used to render Aetna decision; a summary of the applicable issues including a statement of Aetna decision, the criteria used and any clinical reasons for our decision and the relevant portions of Aetna utilization review guidelines.

     Within 2 business days of receiving this information, the Insurance Director must determine if the service or claim is covered, issue a decision, and send a notice to Aetna, the Member, and the Member's treating Provider.

     The Director of Insurance is sometimes unable to determine issues of coverage. If this occurs, the Director of Insurance will forward the Member's case to an IRO. The IRO will have 5 business days to make a decision and send it to the Insurance Director. The Insurance Director will have 1 business day after receiving the IRO's decision to send the decision to Aetna, the Member, and the Member's treating Provider.

Decision:

Medical Necessity decision:

If the IRO decides that Aetna should provide the service, Aetna must authorize the service. If the IRO agrees with Aetna decision to deny the service, the appeal is over. The Member's only further option is to pursue the Member's claim in Superior Court.

Contract Coverage decision:

If the Member disagrees with the Insurance Director's final decision on a contract coverage issue, the Member may request a hearing with the Office of Administrative Hearings ("OAH"). If Aetna disagrees with the Director's final decision, Aetna may also request a hearing before the OAH. A hearing must be scheduled within 30 days of receiving the Director's decision. OAH must promptly schedule and complete a hearing for Appeals from Expedited External Independent Medical Review Appeals decisions.

STANDARD APPEAL PROCESS FOR NON-URGENT SERVICES AND DENIED CLAIMS

Informal Reconsideration (Level One)

Your request: You may obtain Informal Reconsideration of your denied request for a service or a denied claim for services already provided to you if:

- You have coverage with us;
- We denied your request for a covered service or denied your claim for services already provided,
- You do not qualify for an expedited appeal, and

- You or your treating provider asks for Informal Reconsideration within 2 years of the date we first deny the requested service or claim by calling, writing, or faxing your request to:

Name:	Aetna Health Inc./Aetna Health Insurance Company
Title:	National Clinical Appeals Unit
Address National Accounts:	P.O. Box 14001, Lexington, KY 40512
Address Regional Businesses:	P.O. Box 14002, Lexington, KY 40512
Phone:	1-877-665-6736
Fax:	1-860-754-5321

Our acknowledgement: We have 5 business days after we receive your request for Informal Reconsideration ("the receipt date") to send you and your treating provider a notice that we received your request.

Our decision: We have within the following timeframes after the receipt date to decide whether we should change our decision and authorize your requested service or pay your claim. Within that same timeframe, we must send you and your treating provider our written decision. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request for a Pre-Service Claim--within 15 calendar days. A Pre-Service Claims is a claim for a benefit that requires approval of the benefit in advance of obtaining medical care. **You have 60 days to appeal to Level Two.**

If we deny your request for a Concurrent Care Claim Extension-within 15 calendar days. A Concurrent Care Claim Extension is a request to extend or a decision to reduce a previously approved course of treatment. **You have 60 days to appeal to Level Two.**

If we deny your request for a Post-Service Claim--within 30 calendar days. A Post-Service Claim is any claim for a benefit that is not a pre-service claim. **You have 60 days to appeal to Level Two.**

If we grant your request: The decision will authorize the service or pay the claim and the appeal process is complete.

If we refer your case to Level Three: We may decide to skip Level One and Level Two and send your case straight to an independent reviewer at Level Three.

Formal Appeal (Level Two)

Your request: You may request Formal Appeal if we denied your request or claim at Level One. After you receive our Level One denial, you or your treating provider must send us a written request within 60 days to tell us you are appealing to Level Two. To help us make a decision on your appeal, you or your provider should also send us any more information (that you haven't already sent us) to show why we should authorize the requested service or pay the claim.

A Member and/or an authorized representative may attend the Level Two Appeal hearing and question the representative of Aetna and/or any other witnesses, and present their case. The hearing will be informal. A Member's Physician or other experts may testify. Aetna also has the right to present witnesses.

Send your appeal request and information to:

Name:	Aetna Health Inc./Aetna Health Insurance Company
Title:	National Clinical Appeals Unit
Address National Accounts:	P.O. Box 14001, Lexington, KY 40512
Address Regional Businesses:	P.O. Box 14002, Lexington, KY 40512
Phone:	1-877-665-6736
Fax:	1-860-754-5321

Our acknowledgement: We have 5 business days after we receive your request for Formal Appeal ("the receipt date") to send you and your treating provider a notice that we received your request.

Our decision: For a denied service that you have not yet received, we have within the following timeframes after the receipt date to decide whether we should change our decision and authorize your requested service. We will send you and your treating provider our decision in writing. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request for a Pre-Service Claim--within 15 calendar days. A Pre-Service Claims is a claim for a benefit that requires approval of the benefit in advance of obtaining medical care. **You have 30 days to appeal to Level Three.**

If we deny your request for a Concurrent Care Claim Extension-within 15 calendar days. A Concurrent Care Claim Extension is a request to extend or a decision to reduce a previously approved course of treatment. **You have 30 days to appeal to Level Three.**

If we deny your request for a Post-Service Claim--within 30 calendar days. A Post-Service Claim is any claim for a benefit that is not a pre-service claim. **You have 30 days to appeal to Level Three.**

If we grant your request: We will authorize the service or pay the claim and the appeal process is complete.

If we refer your case to Level Three: We may decide to skip Level Two and send your case straight to an independent reviewer at Level Three.

External, Independent Review (Level Three)

Your request: The Member may obtain External Independent Medical Review only after the Member has sought any Appeals through standard and expedited Level One and Level Two. The Member has 30 days after receipt of written notice from Aetna that the Member's Formal Appeal or Expedited Medical Review has been denied to request External Independent Medical Review. The Member must send a written request for External Independent Medical Review and any material justification or documentation to support the Member's request for the covered service or claim for a covered service to:

Name: Priscilla Bugari, R.N.
Title: Director, Aetna National External Review Unit
Address: 11675 Great Oaks Way, Alpharetta, GA 30022
Phone: 1-877-848-5855 (Toll-free number)
Fax: 1-770-346-1087

Neither the Member nor the Member's treating Provider is responsible for the cost of any External Independent Medical Review.

Process:

There are 2 types of External Independent Medical Review Appeals, depending on the issues in the Member's case:

1. Medical Necessity Appeals are cases where Aetna has decided not to authorize a service because Aetna believes the service(s) the Member or the Member's treating Provider are asking for, are not Medically Necessary to treat the Member's condition. The external independent reviewer is a Provider retained by an outside Independent Review Organization ("IRO"), that is procured by the Arizona Insurance Department, and not connected with Aetna. The IRO Provider must be one who typically manages the condition under review.

   Within 5 business days of receiving the Member's or the Director of Insurance's request, or if Aetna initiates an External Independent Medical Review, Aetna must:

   - Mail a written acknowledgement to the Director of Insurance, the Member, and the Member's treating Provider.
   - Send the Director of Insurance: the request for review; the Member's Aetna Certificate of Coverage or Group Insurance Certificate; all medical records and supporting documentation used to render Aetna decision; a summary of the applicable issues including a statement of Aetna decision; the criteria used and clinical reasons for Aetna decision; and the relevant portions of Aetna utilization review guidelines. We must also include the name and credentials of the Provider who reviewed and upheld the denial at the earlier Appeal levels.

   Within 5 business days of receiving Aetna information, the Director of Insurance must send all the submitted information to an expedited, external independent review organization (the "IRO").

   Within 21 business days of receiving the information, the IRO must make a decision and send the decision to the Director of Insurance.

   Within 5 business days of receiving the IRO's decision, the Director of Insurance will mail a notice of the decision to Aetna, the Member, and the Member's treating Provider.

2. Contract Coverage issues are Appeals where Aetna has denied coverage because Aetna believes the requested service is not covered under the Member's Aetna Certificate of Coverage or Group Insurance Certificate. For these Appeals, the Arizona Insurance Department is the external independent reviewer.

   Within 5 business days of receiving the Member's request or if Aetna initiates an External Independent Medical Review, Aetna must:

   - Mail a written acknowledgement of the Member's request to the Director of Insurance, the Member, and the Member's treating Provider.
   - Send the Director of Insurance: the request for review, the Member's Aetna Certificate of Coverage or Group Insurance Certificate; all medical records and supporting documentation used to render Aetna decision; a summary of the applicable issues including a statement of Aetna decision, the criteria used and any clinical reasons for our decision and the relevant portions of Aetna utilization review guidelines.

     Within 15 business days of receiving this information, the Director of Insurance will determine if the service or claim is covered, issue a decision, and send a notice of determination to Aetna, the Member, and the Member's treating Provider.

     The Director of Insurance is sometimes unable to determine issues of coverage. If this occurs or if the Director of Insurance finds that the case involves a medical issue, the Director of Insurance will forward the Member's case to an IRO. The IRO will have 21 business days to make a decision and send it to the Director of Insurance. The Director of Insurance will have 5 business days after receiving the IRO's decision to send the decision to Aetna, the Member, and the Member's treating Provider.

Decision:

Medical Necessity decision:

If the IRO decides that Aetna should provide the service, Aetna must authorize the service regardless of whether judicial review is sought. If the IRO agrees with Aetna decision to deny the service, the Appeal is over. The Member's only further option is to pursue the Member's claim in Superior Court. However, on written request by the IRO, the Member or Aetna, the Director of Insurance may extend the 21-day time period for up to an additional 30 days, if the requesting party demonstrates good cause for an extension.

Contract Coverage decision:

If the Member disagrees with the Insurance Director's final decision on a contract coverage issue, the Member may request a hearing with the Office of Administrative Hearings ("OAH"). If Aetna disagrees with the Director's final decision, Aetna may also request a hearing before the OAH. A hearing must be requested within 30 days of receiving the coverage issue determination. OAH has rules that govern the conduct of their hearing proceedings.

II. The Role of the Director of Insurance.

Arizona law (A.R.S. §20-2533(F)) requires "any Member who files a Complaint or Appeal with the Department relating to an adverse decision to pursue the review process prescribed" by law. This means, that for decisions that are appealable, the Member must pursue the health care Appeals process before the Director or Insurance can investigate a Complaint or Appeal the Member may have against Aetna based on the decision at issue in the Appeal.

The Appeal process requires the Director to:

1. Oversee the Appeals process.
2. Maintain copies of each utilization review plan submitted by Aetna.
3. Receive, process, and act on requests from Aetna for External Independent Medical Review.
4. Enforce the decisions of Aetna.
5. Review decisions of Aetna.
6. Report to the Legislature.
7. Send, when necessary, a record of the proceedings of an Appeal to Superior Court or to the Office of Administrative Hearings (OAH).
8. Issue a final administrative decision on coverage issues, including the notice of the right to request a hearing at the OAH.

III. Obtaining Medical Records.

Arizona law (A.R.S. §12-2293) permits the Member to ask for a copy of their medical records. The Member's request must be in writing and must specify who the Member wants to receive the records. The health care Provider who has the Member's records will provide the Member or the person the Member specifies with a copy of the Member's records.

Designated Decision-Maker: If the Member has a designated health care decision-maker, that person must send a written request for access to or copies of the Member's medical records. The medical records must be provided to the Member's health care decision-maker or a person designated in writing by the Member's health care decision-maker unless the Member limits access to the Member's medical records only to the Member or the Member's health care decision-maker.

Confidentiality: Medical records disclosed under A.R.S. §12-2293 remain confidential. If the Member participates in the Appeal process, the relevant portions of the Member's medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose the Member's medical information to any other people.

IV. Documentation for an Appeal.

If the Member decides to file an Appeal, the Member must give us any material justification or documentation for the Appeal at the time the Appeal is filed. If the Member gathers new information during the course of the Member's Appeal, the Member should give it to us as soon as the Member receives it. The Member must also give Aetna the address and phone number where the Member can be contacted. If the Appeal is already at Expedited External Independent Medical Review, the Member should also send the information to the Department.

V. Receipt of Documents.

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed (the Member's last known address) on the fifth business day after being mailed.

VI. Record Retention.

Aetna shall retain the records of all Complaints and Appeals for a period of at least 7 years.

VII. Fees and Costs.

Nothing herein shall be construed to require Aetna to pay counsel fees or any other fees or costs incurred by a Member in pursuing a Complaint or Appeal.

Once you have completed this Form, submit to:

For Expedited and Standard Level 1 and Level 2

Aetna Health Inc./Aetna Health Insurance Company
Title: National Clinical Appeals Unit
Address National Accounts: P.O. Box 14001, Lexington, KY 40512
Address Regional Businesses: P.O. Box 14002, Lexington, KY 40512
Fax: 860-754-5321

For Expedited, External Independent Review and Standard External Independent Review (Level 3)

Priscilla Bugari, R.N.
Director, Aetna National External Review Unit
11675 Great Oaks Way, Alpharetta, GA 30022
Phone: 1-877-848-5855 Fax: 1-770-346-1087

HealthCare Appeal Request Form

You may use this form to tell your insurer you want to appeal a denial decision.

Insured Member's Name_____ Member ID#_____

Name of representative pursuing appeal, if different from above_____

Mailing Address_____ Phone #_____

City_____ State _____ Zip Code_____

Type of Denial: Denied Claim for Service Already Provided Denied Service Not Yet Received

Name of Insurer that denied the claim/service:_____

If you are appealing your insurer's decision to deny a service you have not yet received, will a 30 day delay in receiving the service likely cause a significant negative change in your health? If your answer is "yes", you may be entitled to an expedited appeal. Your treating provider must sign and send a certification and documentation supporting the need for an expedited appeal.

What decision are you appealing?

_____
_____
_____

(Explain what you want your insurer to authorize or pay for.)

Explain why you believe the claim or service should be covered:

_____
_____
_____

(Attach additional sheets of paper, if needed.)

If you have questions about the appeals process or need help to prepare your appeal, you may call the Department of Insurance Consumer Assistance number at 1-602-364-2499 (within Phoenix) or 1-800-325-2548 (outside Phoenix), or Aetna Health Inc./Aetna Health Insurance Company at 1-800-756-7039.

Make sure to attach everything that shows why you believe your insurer should cover your claim or authorize a service, including: Medical records Supporting documentation (letter from your doctor, brochures, notes, receipts, etc.) ** Also attach the certification from your treating provider if you are seeking expedited review.

_____ _____

Signature of insured or authorized representative Date

Once you have completed this Form, submit to:
Aetna Health Inc./Aetna Health Insurance Company
Title: National Clinical Appeals Unit
Address National Accounts: P.O. Box 14001, Lexington, KY 40512
Address Regional Businesses: P.O. Box 14002, Lexington, KY 40512
Fax: 1-860-754-5321

Provider Certification Form For Expedited Medical Reviews

(You and your provider may use this form when requesting an expedited appeal.)

A patient who is denied authorization for a covered service is entitled to an expedited appeal if the treating provider certifies and provides supporting documentation that the time period for the standard appeal process (about 30 days) "is likely to cause a significant negative change in the patient's medical condition at issue."

PROVIDER INFORMATION

Treating Physician/Provider_____

Phone #_____ FAX #_____

Address_____

City_____ State_____ Zip Code_____

PATIENT INFORMATION

Patient's Name_____ Member ID #_____

Phone #_____

Address_____

City_____ State_____ Zip Code_____

INSURER INFORMATION

Insurer Name_____

Phone #_____ FAX #_____

Address_____

City_____ State_____ Zip Code_____

- Is the appeal for a service that the patient has already received? Yes No
  If "Yes", the patient must pursue the standard appeals process and cannot use the expedited appeals process.
  If "No", continue with this form.
- What service denial is the patient appealing?

  _____

  _____
- Explain why you believe the patient needs the requested service and why the time for the standard appeal process will harm the patient._____

  _____

Attach additional sheets, if needed, and include: Medical records Supporting documentation

If you have questions about the appeals process or need help regarding this certification, you may call the Department of Insurance Consumer Assistance number 1-602-364-2499 (within Phoenix) or 1-800-325-2548 (outside Phoenix). You may also call Aetna Health Inc./Aetna Health Insurance Company at 1-800-756-7039.

I certify, as the patient's treating provider, that delaying the patient's care for the time period needed for the Level One and Level Two appeal processes (about 30 days) is likely to cause a significant negative change in the patient's medical condition at issue.

Provider's Signature_____ **Date**_____

THIS DISCLOSURE FORM IS ONLY A SUMMARY.
THE PLAN'S EVIDENCE OF COVERAGE SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

COMBINED SMALL AND LARGE GROUP DISCLOSURE FORM

AETNA HEALTH INC., AETNA HEALTH INSURANCE COMPANY (ARIZONA)

Please read this notice carefully.

This notice contains important information you should know before you enroll.

* * * * *

This Disclosure form is only a summary.

* * * The Company's policy, Certificate of Coverage (COC) or Evidence of Coverage should be consulted to determine governing contractual provisions * * *

State mandates do not apply to self-funded plans governed by ERISA. If you are unsure if your plan is self-funded and/or governed by ERISA, please confer with your benefits administrator. Specific plan documents supersede general disclosures contained within, as applicable.

A. PRIMARY CARE PHYSICIANS ROSTER

Refer to the Physician Directory for a list of Aetna* participating primary care physicians (PCP), each physician's degree, practice specialty, and year first licensed to practice medicine and, if different, the year initially licensed to practice in Arizona.

B. PREMIUM

The monthly premium cost of your plan will be provided separately by your plan sponsor.

The portion of the premium paid by an employee will depend on the amount of your employer's contribution. We may also adjust the premium rates and/or the manner of calculating premiums effective as of any premium due date upon 60 days prior written notice to contract holder, provided that no such adjustment will be made during the initial term except to reflect changes in applicable law or regulation or a judicial decision having a material impact on the cost of providing covered benefits to members.

The premium may also include an experience factor. If claims are more than expected, the employer may owe additional premium. If claims are less than expected, the employer may receive a refund. This feature applies only to contracts that are retrospectively rated, not fully insured contracts.

Rating and Pertinent Factors

The initial medical rates quoted for your group are subject to adjustment at the commencement of any subsequent rating period based on the then-current new business rates for groups of similar size and demographic characteristics that have purchased similar benefits. Demographic characteristics of a group include age, gender, and group size. They may not include claims experience, health status, industry or duration of coverage.

The rates for your group may be adjusted at the commencement of any rating period based on your group's claims experience, health status, industry or duration since issue. The actual adjustment will be determined by comparing your group's claim experience to the claim experience of other groups of similar size and demographic characteristics.

The foregoing information is subject to change based on future changes to your state's insurance law or other regulatory requirements, as well as future changes to rating practices. Any such changes will be communicated to your group.

Contribution and Participation.

Contribution requirements: For small groups, employer must contribute a minimum of 50% of the employee-only rate. For large groups, employer must contribute a minimum of 50% of the total plan or 75% of the employee-only rate.

Participation requirements: Less than four eligible employees require a minimum of 100% participation, excluding valid benefit waivers. four or more employees require a minimum of 75% participation, excluding valid benefit waivers.

C. MEMBER COST SHARING

Cost sharing refers to the portion of medical services that you pay out of your own pocket. Refer to your plan documents to see which of the following cost-sharing provisions apply to your plan:

- Copay – This may be a flat fee that you pay directly to the health care provider at the time of service.
- Coinsurance – This is a percentage of the fees that you must pay toward the cost of some covered medical expenses. Your health care provider will bill you for this amount.

* Aetna refers to Aetna Health Inc. and/or Aetna Health Insurance Company.

- 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 – The amount of covered inpatient hospital expenses you pay for each hospital confinement before benefits are paid. This deductible is *in addition* to any other copayments or deductibles under your plan.
- Emergency Room Deductible – The amount of covered hospital emergency room expenses you pay each year before benefits are paid. 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.

D. HOW AND WHERE TO OBTAIN SERVICES

1. Selecting a Participating Primary Care Physician.

   At the time of enrollment, each member should select a participating primary care physician (PCP) from the Aetna directory of participating providers to access covered benefits. You may also visit our DocFind® directory at **www.aetna.com** or call Member Services at the toll-free number on your Aetna ID card for help finding participating providers in your area. The choice of a PCP is made solely by the member. If the member is a minor or otherwise incapable of selecting a PCP, the subscriber should select a PCP on the member's behalf.

2. The Primary Care Physician

   For most HMO plans, you are required to select a PCP who participates in the network. The PCP can provide primary health care services as well as coordinate your overall care. You should consult your PCP when you are sick or injured to help determine the care that is needed. Your PCP should issue referrals to participating specialists and facilities for certain services. For some services, your PCP is required to obtain prior authorization from Aetna. Except for those benefits described in the plan documents as direct access benefits, plans with self-referral to participating providers (Aetna Open Access or Aetna Choice POS), plans that include benefits for nonparticipating provider services (Aetna Choice POS or QPOS), or in an emergency, you will need to obtain a referral authorization ("referral") from your PCP before seeking covered nonemergency specialty or hospital care. Check your plan documents for details.

3. Availability of Providers

   We cannot guarantee the availability or continued participation of a particular provider. Either Aetna or any participating provider may terminate the provider contract or limit the number of members that will be accepted as patients. If the PCP initially selected cannot accept additional patients, the member will be notified and given an opportunity to make another PCP selection. The member must then cooperate with Aetna to select another PCP.

4. Changing a PCP

   Members may change their PCP at any time by calling the Member Services toll-free telephone number listed on the Aetna ID card or by written or electronic submission of an Aetna change form. Members may contact us to request a change form or for assistance in completing that form. The change will become effective upon our receipt and approval of the request.

5. Unless an exception is obtained from Aetna, you must receive all routine care through participating providers. In contrast, medical emergencies are covered no matter where or from whom you receive care. When traveling outside the Aetna service area, you can be covered for urgent care through any licensed physician or facility. We cover urgent care services outside your home service area if the services are medically necessary and immediately required because of unforeseen illness, injury or condition and it was not reasonable, given the circumstances, to obtain services through your home service area.

6. See the attached list of locations of contracted hospitals and outpatient treatment centers. Also attached is a map or list of the areas served.

Product	PCP Required?	Referrals Required?	Precertification Required?
HMO	Yes	Yes	Yes
Aetna Open Access HMO	Encouraged	No	Yes
Health Network Only	Encouraged	No	Yes
QPOS	Yes	Yes	Yes
Aetna Choice POS	Encouraged	No	Yes

E. PREAUTHORIZATION AND REFERRAL PROCEDURES

1. Ongoing Reviews

We conduct ongoing reviews of those services and supplies that are recommended or provided by health professionals to determine whether such services and supplies are covered benefits. If we determine that the recommended services and supplies are not covered benefits, the member will be notified. If you wish to appeal such determination, please contact us to seek a review of the determination. Please refer to the Claim Determination Procedures/Complaints and Appeals/External Independent Medical Review/Dispute Resolution section.

2. Continuity of Care

For new Aetna members, coverage will be provided for new members to continue an active, ongoing course of treatment with your current health care provider during a transitional period, upon your written request to us, as follows:

1. For a member with a life-threatening disease or condition on their effective date, the transitional period is 30 days after the member's effective date of coverage; or
2. For a member who has entered the third trimester of pregnancy on their effective date, the transitional period includes the delivery and any care up to 6 weeks after the delivery that is related to the delivery.

If your participating health care provider stops participating with Aetna for reasons other than medical incompetence or unprofessional conduct, on written request, we will continue coverage for an active, ongoing course of treatment with that participating health care provider during a transitional period after the date of the provider's termination, as follows:

1. For a member with a life-threatening disease or condition, the transitional period is 30 days after the date of the participating provider's termination date; or
2. For a member who has entered the third trimester of pregnancy on the participating provider's termination date, the transitional period includes the delivery and any care up to six weeks after the delivery that is related to the delivery.

We will authorize the coverage for the transitional period only if the health care provider agrees to the following in writing:

1. to accept our normal reimbursement rates for similar services;
2. to adhere to our quality standards and to provide medical information related to such care; and
3. to adhere to our policies and procedures.

This provision shall not be construed to require us to provide coverage for benefits not otherwise covered under the COC.

3. Referral Policy

The following points are important to remember 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.
- You should discuss the referral with your PCP to understand what specialist services are being recommended and why.
- If the specialist recommends any additional treatments or tests that are covered benefits, you may need to get another referral from the PCP before receiving the services. If you do not get another referral for these services, you may be responsible for payment.
- Your PCP may indicate on your referral form that your referral will apply to more than one visit to a specialist to whom you have been referred. Depending on the terms of your referral, you may have to acquire another referral form from your PCP for continuing specialist care.
- Except in emergencies, all hospital admissions and outpatient surgery require a prior referral from your PCP and prior authorization by Aetna.
- If it is not an emergency and you go to a doctor or facility without a referral, you must pay the bill.
- Referrals are valid for 90 days as long as the individual remains an eligible member of the plan.
- Coverage for services from nonparticipating providers requires prior authorization by Aetna in addition to a special nonparticipating referral from the PCP. When properly authorized, these services are fully covered, less the applicable cost sharing.
- The referral provides that, except for applicable cost sharing, you will not have to pay the charges for covered benefits, as long as the individual is a member at the time the services are provided.

4. Direct Access

Under Aetna Open Access HMO and Aetna Choice POS plans you 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 documents for details.

Aetna Choice POS and QPOS plans have direct-access benefits. Direct-access benefits allow you to directly access participating providers and nonparticipating providers without a PCP referral, subject to additional cost sharing requirements. Even so, you may be able to reduce your out-of-pocket expenses considerably by using participating providers. Refer to your specific plan brochure for details.

If your plan does not specifically cover direct-access benefits (self-referred or nonparticipating provider 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.

5. Direct Access Ob/Gyn Program

This program allows female members to visit any participating gynecologist for a routine well-woman exam, including a Pap smear, and for gynecologic problems. Gynecologists may also refer a woman directly to other participating providers for covered 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.

6. Health Care Provider Network

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

For up-to-date information about how to locate inpatient and outpatient services, partial hospitalization and other behavioral health care services, please visit our DocFind directory at **www.aetna.com**. If you do not have Internet access and would like a printed provider directory, please contact Member Services at the toll-free number on your Aetna ID card and request a copy.

7. Advance Directives

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

There are three types of advance directives:

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

You can create an advance directive in several ways:

- Get an advance medical directive form from a health care professional. Certain laws require health care facilities that receive Medicare and Medicaid funds to ask all patients at the time they are admitted if they have an advance directive. You don't need an advance directive to receive care. But we are required by law to give you the chance to create one.
- Ask for an advance directive form at state or local offices on aging, bar associations, legal service programs, or your local health department.
- Work with a lawyer to write an advance directive.
- Create an advance directive using computer software designed for this purpose.

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

8. Precertification

Some health care services, like hospitalization and certain outpatient surgery, require "precertification." This means the service must be approved by Aetna before it will be covered under the plan. Check your plan documents for a complete list of services that require this approval. When reviewing a precertification request, we will verify your eligibility and make sure the service is a covered expense under your plan. We also check the cost-effectiveness of the service and we may communicate with your doctor if necessary. If you

qualify, we may enroll you in one of our case management programs and have a nurse call to make sure you understand your upcoming procedure.

When you visit a doctor, hospital or other provider that participates in the Aetna network, someone at the provider's office will contact Aetna on your behalf to get the approval.

If your plan allows you to go outside the Aetna network of providers, you will have to get that approval yourself. In this case, it is your responsibility to make sure the service is precertified, so be sure to talk to your doctor about it. If you do not get proper authorization for out-of-network services, you may have to pay for the service yourself.

You cannot request precertification after the service is performed. To precertify services, call the number shown on your Aetna ID card.

9. We will not retroactively deny covered non-emergency treatment that had prior authorization under our written policies.

10. Utilization Review/Patient Management

` We have developed a patient management program to assist in determining what health care services are covered under the health plan and the extent of such coverage. The program assists you in receiving appropriate health care and maximizing coverage for those health care services. You can avoid receiving an unexpected bill with a simple call to Member Services. You can find out if your preventive care service, diagnostic test or other treatment is a covered benefit - **before you receive care** - just by calling the toll-free number on your ID card. In certain cases, we review your request to be sure the service or supply is consistent with established guidelines and is included or a covered benefit under your plan. We call this "utilization management review."

We follow specific rules to help us make your health a top concern:

- Aetna employees are not compensated based on denials of coverage.
- We do not encourage denials of coverage. In fact, our utilization review staff is trained to focus on the risks of members not adequately using certain services.

Where such use is appropriate, our Utilization Review/Patient Management staff uses nationally recognized guidelines and resources, such as The Milliman Care Guidelines® to guide the precertification, concurrent review and retrospective review processes. To the extent certain Utilization Review/Patient Management functions are delegated to IDSs, IPAs or other provider groups ("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 you of the appeal process.

For more information concerning utilization management, you may request a free copy of the criteria we use to make specific coverage decisions by contacting Member Services.

You may also visit **www.aetna.com/about/cov_det_policies.html** to find our Clinical Policy Bulletins and some utilization review policies. Doctors or health care professionals who have questions about your coverage can write or call our Patient Management department. The address and phone number are on your ID card.

11. 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.

12. 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.

13. 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 health care services. Our 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.

14. Point of Service Plan

We offer Point of Service (POS) plans to employers. POS plans allow members to self-refer to providers within the plan's network or to seek the services of providers who are not contracted with the plan.

When members do not seek services through their PCP or on referral of their PCP, payment of a deductible and of a portion of the allowed charges (called coinsurance) is required. Certain procedures and elective hospital admissions may still require precertification by the plan.

F. 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.

After-Hours Care

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

What to Do Outside Your Aetna HMO Service Area

Members who are traveling outside their Aetna service area or students who are away at school are covered for emergency and urgently needed care. Urgent care may be obtained from a private practice physician, a walk-in clinic, an urgent care center or an emergency facility. Certain conditions, such as severe vomiting, earaches, sore throats or fever, are considered "urgent care" outside your Aetna service area and are covered in any of the above settings.

If, after reviewing information submitted to us by the provider that supplied care, the nature of the urgent or emergency problem does not qualify for coverage, it may be necessary to provide us with additional information. We will send you an Emergency Room Notification Report to complete, or a Member Services representative can take this information by telephone.

Follow-up Care after Emergencies

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

G. PRESCRIPTION DRUGS

If your plan covers outpatient prescription drugs, your plan may include a preferred drug list (also known as a "drug formulary"). The preferred drug list includes a list of prescription drugs that, depending on your prescription drug benefits plan, are covered on a preferred basis. Many drugs, including many of those listed on the preferred drug list, are subject to rebate arrangements between Aetna and the manufacturer of the drugs. Such rebates are not reflected in and do not reduce the amount you pay to your pharmacy for a prescription drug. In addition, in circumstances where your prescription plan utilizes copayments or coinsurance calculated on a percentage basis or a deductible, your costs may be higher for a preferred drug than they would be for a nonpreferred drug. For information regarding how medications are reviewed and selected for the preferred drug list, please refer to **www.aetna.com** or the Aetna Preferred Drug (Formulary) Guide. Printed Preferred Drug Guide information will be provided, upon request or if applicable, annually for current members and upon enrollment for new members. Additional information can be obtained by calling Member Services at the toll-free number listed on your ID card. The medications listed on the preferred drug list are subject to change in accordance with applicable state law.

Your prescription drug 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 you to use such drugs, your physician (or pharmacist in the case of antibiotics and analgesics) may contact us 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 that requires a trial of one or more "prerequisite-therapy" medications before a "step-therapy"medication will be covered. If it is medically necessary for you to use a medication subject to these requirements prior to completing the step therapy, your physician, you or your authorized representative 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.

Ask your treating physician(s) 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 Aetna Rx Home Delivery® mail-order prescription program or the Aetna Specialty Pharmacy® specialty drug program, you will be acquiring these prescriptions through an affiliate of Aetna. Aetna Rx Home Delivery's and Aetna Specialty Pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts they may receive from wholesalers, manufacturers, suppliers and distributors. The negotiated charge with Aetna Rx Home Delivery, LLC. and Aetna Specialty Pharmacy may be higher than the cost of purchasing drugs and providing pharmacy services.

Updates to the Drug Formulary

For up-to-date formulary information, visit **www.aetna.com/formulary/** or call Member Services at the toll-free number on your Aetna ID card. If you do not have Internet access, you may contact Member Services at the toll-free number on your ID card to find out how a specific drug is covered.

H. BEHAVIORAL HEALTH NETWORK

Behavioral health care services are managed by Aetna, except for certain HMO-based health plans in New York that are managed by an independently contracted behavioral health care organization. Aetna and the behavioral health care organization are responsible for, in part, making initial coverage determinations and coordinating referrals to providers. As with other coverage determinations, you may appeal adverse behavioral health care coverage determinations in accordance with the terms of your health plan.

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

If you have an emergency, call 911 or your local emergency hotline, if available. For routine services, access covered behavioral health services available under your health plan by the following methods:

- Call the toll-free Behavioral Health number (where applicable) listed on your ID card or, if no number is listed, call the Member Services number listed on your ID card for the appropriate information.
- Where required by your plan, call your PCP for a referral to the designated behavioral health provider group.
- When applicable, an employee assistance or student assistance professional may refer you to your designated behavioral health provider group.

You can access most outpatient therapy services without a referral or preauthorization. However, you should first consult Member Services to confirm that any such outpatient therapy services do not require a referral or preauthorization.

Behavioral Health Provider Safety Data Available

For information about our Behavioral Health provider network safety data, visit **www.aetna.com/docfind** and select the "Get info on Patient Safety and Quality" link. If you do not have Internet access, you may call Member Services at the toll-free number shown on your Aetna ID card to request a printed copy of this information.

Behavioral Health Depression Prevention Programs

Aetna Behavioral Health offers two prevention programs for our members: Perinatal Depression Education, Screening and Treatment Referral Program, also known as Beginning Right® Depression Program, and Identification and Referral of Adolescent Members Diagnosed With Depression Who Also Have Comorbid Substance Abuse Needs. For more information on either of these prevention programs and how to use the programs, ask Member Services for the phone number of your local Care Management Center.

I. HOW AETNA COMPENSATES YOUR PHYSICIAN

How Aetna Pays In-Network Providers

All the providers in our network directory are independent. They are free to contract with other health plans. Providers join our network by signing contracts with us. Or they work for organizations that have contracts with us. We pay network providers in many different ways. Sometimes we pay a rate for a specific service and sometimes for an entire course of care (for example, a flat fee for a pregnancy without complications). In certain circumstances, some providers are paid a pre-paid amount per month per Aetna member (capitation). We may also provide additional incentives to reward physicians for delivering cost-effective quality care.

We pay some network hospitals by the day (per diem) and we pay others in a different way, such as a percentage of their standard billing rates. We encourage you to ask your providers how they are paid for their services.

How Aetna Pays Out-of-Network Providers

Some of our plans pay for services from providers who are not in our network. Many plans pay for services based on what is called the "reasonable," "usual and customary" or "prevailing" charge. Other plans pay based on our standard fees for care received from a network provider, or based on a percentage of Medicare's fees. ***When we pay less than what your provider charges, your provider may require you to pay the difference. This is true even if you have reached your plan's out-of-pocket maximum.*** Here is how we figure out what we will pay for each type of plan.

Prevailing Charge Plans

Step 1: We review the data.
We get information from Ingenix, which is owned by United HealthCare. Health plans send Ingenix copies of claims for services they received from providers. The claims include the date and place of the service, the procedure code, and the provider's charge. Ingenix combines this information into databases that show how much providers charge for just about any service in any zip code.

Step 2: We calculate the portion we pay.
For most of our health plans, we use the 80th percentile to calculate how much to pay for out-of-network services. Payment at the 80th percentile means 80 percent of charges in the database are the same or less for that service in a particular zip code.

If there are not enough charges (less than 9) in the databases for a service in a particular zip code, we may use "derived charge data" instead. "Derived charge data" is based on the charges for comparable procedures, multiplied by a factor that takes into account the relative complexity of the procedure that was performed. We also use derived charge data for our student health plans and Aetna Affordable Health Choices® plans.

We also may consider other factors to determine what to pay if a service is unusual or not performed often in your area. These factors can include:

- The complexity of the service
- The degree of skill needed
- The provider's specialty
- The prevailing charge in other areas
- Aetna's own data

Step 3: We refer to your health plan.
We pay our portion of the prevailing charge as listed in your health plan. You pay your portion (called "coinsurance") and any deductible.

For example, your out of network doctor charges $120 for an office visit. Your plan covers 70 percent of the "reasonable," "usual and customary" or "prevailing" charge. Let's say the prevailing charge is $100. And let's say you already met your deductible. Aetna would pay $70. You would pay the other $30. Your doctor may also bill you for the $20 difference between the prevailing charge ($100) and the billed charge ($120). In this case, your doctor could bill you for a total of $50.

The Prevailing Charge Databases
The New York State Attorney General (NYAG) investigated the conflicts of interest related to the ownership and use of Ingenix data. Under an agreement with the NYAG, UnitedHealth Group agreed to stop using the Ingenix databases when an independent database (not owned by a health insurer) is created. In a separate agreement with NYAG in January 2009, Aetna agreed to use this new database when it is ready. We also will work with the new database owner to create online tools to give you better

information about the cost of your care when using providers outside our network.

Fee Schedule Plans

Step 1: We compare the provider's bill to our fee schedule and your health plan.
Your plan may say that we will pay the provider based on our fee schedule for network doctors, or a certain percentage of that fee schedule, or a certain percentage of what Medicare pays. For example, your plan may say we pay 125 percent of what we pay a network doctor for the same service.

Let's say you have your appendix removed. Our network rate for that surgery is $1,600. We multiply $1,600 by 125 percent to get $2,000. We call this the "recognized" or "allowed" amount.

Step 2: We calculate the portion we pay.
Your plan also says that you must pay "coinsurance." This is your share of the "recognized" or "allowed" amount.

For example, your share may be 30 percent. In that case, we pay 70 percent of the $2,000 allowed amount, which is $1,400. You pay your provider your 30 percent coinsurance, which is $600. Your provider may also ask you to pay the $500 difference between the $2,500 bill and the $2,000 "recognized" or "allowed" amount. In this case, your provider could bill you $1,100 in total.

Exceptions

Some "prevailing charge" plans set the prevailing charge at a different percentile. For some claims (like those from hospitals and outpatient centers) we may use other information and data sources to determine the charge. And some of our plans pay based on a different kind of fee schedule. Also, for some non-participating providers we may pay based on other contractual arrangements.

Our provider claims codes and payment policies may also affect what we pay for a claim. Aetna may 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. The effects of these policies will be reflected in your Explanation of Benefits documents.

How Aetna Pays for Out-of-Network Behavioral Health Benefits

We negotiate rates with psychiatrists, psychologists, counselors and other appropriately licensed and credentialed behavioral health care providers to help you save money. We refer to these providers as being "in our network."

Quality Enhancement:

In some regions, the QE program 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 PCP, management of chronic illnesses like asthma, diabetes and congestive heart failure; whether the physician is accepting new patients, and participation in our electronic claims and referral submission program.

Technology Review

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

- Study medical research and scientific evidence on the safety and effectiveness of medical technologies.
- Consider position statements and clinical practice guidelines from medical and government groups, including the federal Agency for Health care Research and Quality.
- Seek input from relevant specialists and experts in the technology.
- Determine whether the technologies are experimental or investigational.

You can find out more on new tests and treatments in our Clinical Policy Bulletins. See the Clinical Policy Bulletins section for more information.

J. MEDICAL NECESSITY

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; and
- 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, we 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 (including but not limited to Milliman & Robertson Health Care Management Guidelines©, InterQual® ISD criteria and our Coverage Policy Bulletins);
- professional standards of safety and effectiveness that 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; and
- any other relevant information brought to Aetna's attention.

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.

All covered benefits will be covered in accordance with the guidelines determined by Aetna.

K. CLINICAL POLICY BULLETINS

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

Aetna CPBs do not constitute medical advice. Treating providers are solely responsible for medical advice and for your treatment. You should discuss any CPB related to your coverage or condition with your treating provider.

While our CPBs are developed to assist in administering plan benefits, they do not constitute a description of plan benefits. Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. You and your providers will need to consult the benefit plan to determine if there are any exclusions or other benefit limitations applicable to this service or supply.

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

L. COMPLAINT PROCEDURES

The following procedures provide the member with the guidelines that govern the Claim Determination Procedures/Complaints and Appeals/External Independent Medical Review/Dispute Resolution.

When the member's coverage is first effective, the member will receive a separate information packet that contains additional important information about how to appeal decisions made by Aetna.

Upon the subsequent renewal of the member's coverage, the member may obtain a replacement Appeal information packet by contacting Member Services at 1-800-756-7039.

During each level of the process, the member is encouraged to be as specific as possible as to the member's desired resolution. At each step in the process, the member will be informed of the next level of appeal and any relevant procedures, addresses and phone numbers.

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.

M. Filing a Complaint or Appeal

We are committed to addressing your coverage issues, complaints and problems. If you have a coverage issue or other problem, call Member Services at the toll-free number on your ID card or e-mail us from your secure Aetna Navigator® member website. Click on "Contact Us" after you log on. You can also contact Member Services at **www.aetna.com**. If Member Services is unable to resolve your issue to your satisfaction, it will be forwarded to the appropriate department for handling.

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

About Coverage Decisions

Sometimes we receive claims for services that may not be covered by your health benefits plan or that aren't in line with the terms of your plan. It can be confusing — even to your doctors. Our job is to make coverage decisions based on your specific benefits plan.

If a claim is denied, we'll send you a letter to let you know. If you don't agree you can file an appeal. To file an appeal, follow the directions in the letter that explains that your claim was denied. Our appeals decisions will be based on your plan provisions and any state and federal laws or regulations that apply to your plan. You can learn more about the appeal procedures for your plan from your plan documents.

CLAIM DETERMINATION/COMPLAINTS AND APPEALS/EXTERNAL INDEPENDENT MEDICAL REVIEW/DISPUTE RESOLUTION PROCEDURES

Claim Determination Procedures

A claim occurs whenever a member or the member's authorized representative requests pre-authorization as required by the plan from Aetna, a referral as required by the plan from a participating provider or requests payment for services or treatment received. As an Aetna member, you are not required to submit claims for in-network services. However, if you receive a bill for covered benefits, please submit the bill to us for payment. Send the itemized bill for payment with your identification number clearly marked to the address shown on your ID card.

We will make a decision on the claim. For urgent care claims and preservice claims, we will send you written notification of the determination, whether adverse or not adverse. For other types of claims, the member may only receive notice if we make an adverse benefit determination.

Adverse benefit determinations are decisions made by Aetna that result in denial, reduction, or termination of a benefit or the amount paid for it. It also means a decision not to provide a benefit or service. Adverse benefit determinations can be made for one or more of the following reasons:

- Utilization Review. We determine that the service or supply is not medically necessary or is an experimental or investigational procedure;
- No Coverage. We determine that a service or supply is not covered by the plan. A service or supply is not covered if it is not included in the list of covered benefits;
- It is excluded from coverage;
- An Aetna limitation has been reached; or
- Eligibility. We determine that the subscriber or subscriber's covered dependents are not eligible to be covered by Aetna.

Written notice of an adverse benefit determination will be provided to the member within the following time frames. Under certain circumstances, these time frames may be extended. The notice will provide important information that will assist the member in making an appeal of the adverse benefit determination, if the member wishes to do so. Please see the Complaints and Appeals section of the COC for more information about appeals.

Aetna Time Frame for Notification of an Adverse Benefit Determination	
Type of Claim	Aetna Response Time from Receipt of Claim
Urgent Care Claim. A claim for medical care or treatment where delay could seriously jeopardize the life or health of the member, the ability of the member to regain maximum function; or subject the member to severe pain that cannot be adequately managed without the requested care or treatment.	As soon as possible but not later than 72 hours.
Preservice Claim. A claim for a benefit that requires preauthorization of the benefit in advance of obtaining medical care.	Within 15 calendar days.
Concurrent Care Claim Extension. A request to extend a course of treatment previously preauthorized by Aetna.	If an urgent care claim, as soon as possible but not later than 24 hours. Otherwise, within 15 calendar days.
Concurrent Care Claim Reduction or Termination. Decision to reduce or terminate a course of treatment previously preauthorized by Aetna.	With enough advance notice to allow the member to Appeal.
Postservice Claim. A claim for a benefit that is not a preservice claim.	Within 15 calendar days Within 30 calendar days

COMPLAINTS AND APPEALS

We have procedures for members to use if they are dissatisfied with a decision that we have made or with our operations. The procedure the member needs to follow will depend on the type of issue or problem the member has.

- Appeal. An appeal is a request to Aetna to reconsider an adverse benefit determination. The appeal procedure for an adverse benefit determination has two levels.
- Complaint. A Complaint is an expression of dissatisfaction about quality of care or our operations.

A. Complaints.

If the member is dissatisfied with the administrative services the member receives from Aetna or wants to complain about a participating provider, call or write Member Services within 30 calendar days of the incident. Please include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. We will review the information and provide the member with a written response within 30 calendar days of the receipt of the complaint, unless additional information is needed and it cannot be obtained within this time frame. The response will explain what you need to do to seek an additional review.

B. Appeals of Adverse Benefit Determinations.

We will send a written notice of an adverse benefit determination. The notice will include the reason for the decision and it will explain what steps must be taken if you wish to appeal. The notice will also identify your rights to receive additional information that may be relevant to an appeal. Requests for an appeal must be made in writing within 2 years from the date of the notice.

A member may also choose to have another person (an authorized representative) make the appeal on his or her behalf by providing us with written consent. However, in case of an urgent care claim or a preservice claim, a physician may represent the member in the appeal.

We provide for two levels of appeal of the adverse benefit determination. If you decide to appeal to the second level, the request must be made in writing within 60 calendar days from the date of the notice to the following address. The following chart summarizes some information about how the appeals are handled for different types of claims.

THIS DISCLOSURE FORM IS ONLY A SUMMARY.
THE PLAN'S EVIDENCE OF COVERAGE SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

Name:	Aetna Health Inc./Aetna Health Insurance Company
Title:	National Clinical Appeals Unit
Address National Accounts:	P.O. Box 14001, Lexington, KY 40512
Address Regional Businesses:	P.O. Box 14002, Lexington, KY 40512
Phone:	1-877-665-6736
Fax:	1-860-754-5321

Aetna Time Frame for Notification of an Adverse Benefit Determination		
Type of Claim	Level One Appeal Aetna Response Time from Receipt of Appeal	Level Two Appeal Aetna Response Time from Receipt of Appeal
Urgent Care Claim. A claim for medical care or treatment where delay could seriously jeopardize the life or health of the member, the ability of the member to regain maximum function; or subject the member to severe pain that cannot be adequately managed without the requested care or treatment.	1 business day or 36 hours from receipt, whichever is less. Review provided by Aetna personnel not involved in making the adverse benefit determination.	Within 36 hours. Review provided by Aetna Appeals Committee.
Preservice Claim. A claim for a benefit that requires approval of the benefit in advance of obtaining medical care.	Within 15 calendar days. Review provided by Aetna personnel not involved in making the adverse benefit determination.	Within 15 calendar days. Review provided by Aetna Appeals Committee.
Concurrent Care Claim Extension. A request to extend or a decision to reduce a previously approved course of treatment.	Treated like an urgent care claim or a preservice claim depending on the circumstances.	Treated like an urgent care claim or a preservice claim depending on the circumstances.
Postservice Claim. Any claim for a benefit that is not a preservice claim.	Within 30 calendar days. Review provided by Aetna personnel not involved in making the adverse benefit determination.	Within 30 calendar days. Review provided by Aetna Appeals Committee.

A member and/or an authorized representative may attend the Level-Two Appeal hearing and question the representative of Aetna and/or any other witnesses and present their case. The hearing will be informal. A member's physician or other experts may testify. We also have the right to present witnesses.

C. External Independent Medical Review.

1. Eligibility

The member may obtain external independent medical review only after the member has sought any appeals through standard levels one (informal reconsideration) and two (formal) appeal above or through expedited medical review. The member has 30 days after receipt of written notice from Aetna that the member's formal appeal or expedited medical review has been denied to request external independent medical review. Neither the member nor the member's treating provider is responsible for the cost of any external independent medical review. The member must send a written request for external independent medical review and any material justification or documentation to support the member's request for the covered service or claim for a covered service to:

Name:	Priscilla Bugari, R. N.
Title:	Director, Aetna National External Review Unit
Address:	11675 Great Oaks Way, Alpharetta, GA 30022
Phone:	1-877-848-5855 (Toll-free number)
Fax:	1-770-346-1087

2. Process: There are two types of external independent medical review appeals, depending on the issues in the member's case:

a. Medical necessity appeals are cases where we have decided not to authorize a service because we believe the service(s) the member or the member's treating provider are asking for, are not medically necessary to treat the member's condition. The external independent reviewer is a provider retained by an outside independent review organization (IRO), that is procured by the Arizona Insurance Department, and not connected with Aetna. The IRO provider must be one who typically manages the condition under review.

Within five business days of receiving the member's or the Director of Insurance's request, or if we initiate an external independent medical review, we must:

- Mail a written acknowledgement to the Director of Insurance, the member, and the member's treating provider.
- Send the Director of Insurance: the request for review; the member's COC; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of Aetna's decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the provider who reviewed and upheld the denial at the earlier appeal levels.

Within five business days of receiving our information, the Director of Insurance must send all the submitted information to an expedited, IRO.

Within 21 business days of receiving the information, the IRO must make a decision and send the decision to the Director of Insurance.

Within five business days of receiving the IRO's decision, the Director of Insurance will mail a notice of the decision to Aetna, the member, and the member's treating provider.

b. Contract coverage issues are appeals where we have denied coverage because we believe the requested service is not covered under the member's COC. For these appeals, the Arizona Insurance Department is the external independent reviewer.

Within five business days of receiving the member's request or if we initiate an external independent medical review, we must:

- Mail a written acknowledgement of the member's request to the Director of Insurance, the member, and the member's treating provider.
- Send the Director of Insurance: the request for review, the member's COC; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision, the criteria used and any clinical reasons for our decision and the relevant portions of our utilization review guidelines.

Within 15 business days of receiving this information, the Director of Insurance will determine if the service or claim is covered, issue a decision, and send a notice of determination to Aetna, the member, and the member's treating provider.

The Director of Insurance is sometimes unable to determine issues of coverage. If this occurs or if the Director of Insurance finds that the case involves a medical issue, the Director of Insurance will forward the member's case to an IRO. The IRO will have 21 business days to make a decision and send it to the Director of Insurance. The Director of Insurance will have 5 business days after receiving the IRO's decision to send the decision to Aetna, the member, and the member's treating provider.

3. Decision

Medical Necessity Decision:

If the IRO decides that we should cover the service, we must authorize the service regardless of whether judicial review is sought. If the IRO agrees with our decision to deny the service, the appeal is over. The member's only further option is to pursue the member's claim in Superior Court. However, on written request by the IRO, the member or Aetna, the Director of Insurance may extend the 21-day time period for up to an additional 30 days, if the requesting party demonstrates good cause for an extension.

Contract Coverage Decision:

If the member disagrees with the Insurance Director's final decision on a contract coverage issue, the member may request a hearing with the Office of Administrative Hearings (OAH). If we disagree with the Director's final decision, we may also request a hearing before the OAH. A hearing must be requested within 30 days of receiving the coverage issue determination. OAH has rules that govern the conduct of their hearing proceedings.

Expedited Appeals Process For Urgently Needed Services The Member Has Not Yet Received

A. Expedited Medical Review (Level One).

1. Eligibility

The member may obtain Expedited Medical Review of the denied request for a covered service that has not already been provided if:

- The member has coverage with Aetna,
- We have denied the member's request for a covered service, and
- The member's physician or treating provider certifies in writing and provides supporting documentation that the time required to process the member's request through the standard informal reconsideration process described above and standard formal appeal process described above is likely to cause a significant negative change in the member's medical condition. This certification is not challengeable by Aetna.

The member's treating provider must send the certification and documentation to:

Name: Aetna Health Inc./Aetna Health Insurance Company
Title: National Clinical Appeals Unit
Address National Accounts:
P.O. Box 14001, Lexington, KY 40512
Address Regional Businesses:
P.O. Box 14002, Lexington, KY 40512
Phone: 1-877-665-6736
Fax: 1-860-754-5321

2. Decision

We have one business day after receiving the information from the member's treating provider to decide whether we should change our decision and authorize the member's requested service. Within that same business day, we must mail to the member and the member's treating provider our decision in writing. Notice of the decision will include criteria used to make the decision, clinical reasons for the decision, and any references to supporting documentation.

If the member's appeal is an issue of medical necessity, before making the decision, we will consult with a:

Physician or other appropriate licensed health care professional, or

An out-of-state provider, physician or other health care professional who is licensed in another state and who is not licensed in Arizona and who typically manages the member's medical condition under review.

a. Denial Upheld

If we agree that the covered service should have been denied, we will telephone the member and the member's treating provider and will mail to the member and the member's treating provider a notice of the adverse decision and of the member's option to immediately proceed to an expedited appeal level-two appeal.

b. Denial Reversed

If we agree that the covered service should have been provided, we must authorize the service and the member's appeal is ended.

B. Expedited Appeal (Level Two).

1. Eligibility

If we deny a member's request at expedited medical review level one for a covered service that has not already been provided, the member may request an expedited appeal. After the member receives our level-one denial, the member's treating provider must immediately send a written request to us (to the same person and address listed above under Level One to notify us that the member is appealing to level-two appeal. The member's treating provider may want to send any additional information, not previously submitted to Aetna, to support the member's request for the service.

2. Process

Medically necessary appeal decisions will be made by any provider who is qualified in a scope of practice similar to that of the treating provider, or one who typically manages the medical condition under appeal. We will select the provider who shall review the appeal and render the decision.

Coverage issue appeal decisions are not required to be rendered by a participating provider.

3. Decision

We have three business days after receipt of the request for an expedited appeal level-two appeal. to notify the member and the member's treating provider of the decision.

a. Denial Upheld

If we agree that the covered service should have been denied, the member may immediately appeal to external independent medical review. We will telephone the member and the member's treating provider and will mail to the member and the member's treating provider a notice of the denial and of the member's option to immediately proceed to expedited external independent review.

b. Denial Reversed

If we agree that the covered service should have been provided, we must authorize the service and the member's appeal is ended.

c. We may decide to skip level-two appeal and send the member's case straight to expedited external independent review. We must send the member and the member's treating provider a written acknowledgment that the appeal was submitted for expedited external independent medical review.

C. Expedited External Independent Medical Review.

1. Eligibility

The member may appeal to expedited external independent medical review only after the member has appealed through level one. The member has five business days after receiving our level one decision to send us the member's written request for expedited external independent medical review. The member's request should include any additional information to support the member's request for the service. The member and the member's treating provider are not responsible for the cost of any expedited external independent medical review.

The member should send the request and any additional supporting information to:

Name: Priscilla Bugari, R.N.
Title : Director, Aetna National External Review Unit
Address: 11675 Great Oaks Way, Alpharetta, GA 30022
Phone: 1-877-848-5855 (Toll-free number)
Fax: 1-770-346-1087

2. Process:

There are two types of expedited external independent medical review appeals, depending on the issues in the member's case:

a. Medical necessity appeals are cases where we have decided not to authorize a service because we believe the service(s) the member or the member's treating provider are asking for, are not medically necessary to treat the member's condition. The expedited external independent reviewer is a provider retained by an outside IRO that is procured by the Arizona Insurance Department and not connected with Aetna. The IRO provider must be a provider who typically manages the condition under review.

Within one business day of receiving the member's request, we must:

- Mail a written acknowledgement of the request to the Director of Insurance, the member, and the member's treating provider.
- Send the Director of Insurance: the request for review; the member's COC; all medical records and supporting documentation used to render our decision; a summary of the applicable issues, including a statement of Aetna's decision, the criteria used and clinical reasons for our decision, and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the provider who reviewed and upheld the denial at the earlier appeal levels.

Within two business days of receiving our information, the Director of Insurance must send all the submitted information to an expedited, external IRO.

Within five business days of receiving the information, the IRO must make a decision and send the decision to the Insurance Director.

Within one business day of receiving the IRO's decision, the Insurance Director must mail a notice of the decision to Aetna, the member, and the member's treating provider.

b. Contract coverage issues are appeals where we have denied coverage because we believe the requested service is not covered under the member's COC. For these appeals, the Arizona Insurance Department is the expedited external independent reviewer.

Within one business day of receiving the member's request, we must:

- Mail a written acknowledgement of the member's request to the Insurance Director, the member, and the member's treating provider.
- Send the Director of Insurance: the request for review, the member's COC; all medical records and supporting documentation used to render our decision; a summary of the applicable issues, including a statement of our decision, the criteria used and any clinical reasons for our decision and the relevant portions of our utilization review guidelines.

Within two business days of receiving this information, the Insurance Director must determine if the service or claim is covered, issue a decision, and send a notice to Aetna, the member, and the member's treating provider.

The Director of Insurance is sometimes unable to determine issues of coverage. If this occurs, the Director of Insurance will forward the member's case to an IRO. The IRO will have five business days to make a decision and send it to the Insurance Director. The Insurance Director will have one business day after receiving the IRO's decision to send the decision to Aetna, the member, and the member's treating provider.

3. Decision

Medical Necessity Decision:

If the IRO decides that we should provide the service, we must authorize the service. If the IRO agrees with our decision to deny the service, the appeal is over. The member's only further option is to pursue the member's claim in Superior Court.

Contract Coverage Decision:

If the member disagrees with the Insurance Director's final decision on a contract coverage issue, the member may request a hearing with the OAH. If we disagree with the Director's final decision, we may also request a hearing before the OAH. A hearing must be scheduled within 30 days of receiving the Director's decision. OAH must promptly schedule and complete a hearing for appeals from expedited external independent medical review appeals decisions.

D. The Role of the Director of Insurance

Arizona law (A.R.S. §20-2533(F)) requires "any member who files a complaint or appeal with the Department relating to an adverse decision to pursue the review process prescribed" by law. This means, that for decisions that are appealable, the member must pursue the health care appeals process before the Director of Insurance can investigate a complaint or appeal the member may have against Aetna based on the decision at issue in the appeal.

The appeal process requires the Director to:

1. Oversee the appeals process
2. Maintain copies of each utilization review plan submitted by Aetna
3. Receive, process, and act on requests from Aetna for external independent medical review
4. Enforce the decisions of Aetna
5. Review decisions of Aetna
6. Report to the Legislature
7. Send, when necessary, a record of the proceedings of an appeal to Superior Court or to the OAH
8. Issue a final administrative decision on coverage issues, including the notice of the right to request a hearing at the OAH

E. Obtaining Medical Records

Arizona law (A.R.S. §12-2293) permits the member to ask for a copy of their medical records. The member's request must be in writing and must specify who the member wants to receive the records. The health care provider who has the member's records will provide the member or the person the member specifies with a copy of the member's records.

Designated Decision Maker: If the member has a designated health care decision maker, that person must send a written request for access to or copies of the member's medical records. The medical records must be provided to the member's health care decision maker or a person designated in writing by the member's health care decision maker unless the member limits access to the member's medical records only to the member or the member's health care decision maker.

Confidentiality: Medical records disclosed under A.R.S. §12-2293 remain confidential. If the member participates in the appeal process, the relevant portions of the member's medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose the member's medical information to any other people.

F. Documentation for an Appeal

If the member decides to file an appeal, the member must give us any material justification or documentation for the appeal at the time the appeal is filed. If the member gathers new information during the course of the member's appeal, the member should give it to us as soon as the member receives it. The member must also give us the address and phone number where the member can be contacted. If the appeal is already at expedited external independent medical review, the member should also send the information to the Department.

G. Receipt of Documents

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed (the member's last known address) on the fifth business day after being mailed.

H. Record Retention

We will retain the records of all complaints and appeals for a period of at least seven years.

I. Fees and Costs

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

DISPUTE RESOLUTION

Any controversy, dispute or claim between Aetna on the one hand and one or more interested parties on the other hand arising out of or relating to the Group Agreement or Group Policy, whether stated in tort, contract, statute, claim for benefits, bad faith, professional liability or otherwise ("Claim"), shall be settled by confidential binding arbitration administered by the American Arbitration Association ("AAA") before a sole arbitrator ("Arbitrator"). Judgment on the award rendered by the Arbitrator ("Award") may be entered by any court having jurisdiction thereof. If the AAA declines to administer the case and the parties do not agree on an alternative administrator, a sole neutral arbitrator shall be appointed upon petition to a court having jurisdiction. Aetna and Interested Parties hereby give up their rights to have Claims decided in a court before a jury.

Any Claim alleging wrongful acts or omissions of participating or nonparticipating providers shall not include Aetna. A member must exhaust all complaint, appeal and independent external review procedures prior to the commencement of arbitration hereunder. No person may recover any damages arising out of or related to the failure to approve or provide any benefit or coverage beyond payment of or coverage for the benefit or coverage where (i) Aetna has made available independent external review and (ii) Aetna has followed the reviewer's decision. Punitive damages may not be recovered as part of a Claim under any circumstances. No interested party may participate in a representative capacity or as a member of any class in any proceeding arising out of or related to the Group Agreement or Group Policy. This agreement to arbitrate shall be specifically enforced even if a party to the arbitration is also a party to another proceeding with a third party arising out of the same matter.

M. Member Rights & Responsibilities

You have the right to receive a copy of our Member Rights and Responsibilities Statement. This information is available to you at **www.aetna.com/about/MemberRights.** You can also obtain a print copy by contacting Member Services at the number on your ID card.

N. Interpreter/Hearing Impaired

When you require assistance from an Aetna representative, call us during regular business hours at the number on your ID card. Our representatives can:

- Answer benefits questions
- Help you get referrals
- Find care outside your area
- Advise you on how to file complaints and appeals
- Connect you to behavioral health services (if included in your plan)
- Find specific health information
- Provide information on our Quality Management program, which evaluates the ongoing quality of our services

Spanish-speaking hotline - 1-800-533-6615
Multilingual hotline - 1-888-982-3862
(140 languages are available. You must ask for an interpreter.)
TDD 1-800-628-3323 (hearing impaired only)

O. Quality Management Programs

We have a comprehensive quality measurement and improvement strategy, and do not view it as an isolated, departmental function. Rather, we integrate quality management and metrics into all that we do. For details on our program, goals and our progress on meeting those goals, go to **www.aetna.com/members/health_coverage/quality/quality.html**. If you do not have Internet access and would like a hard copy of the information referenced here, please contact Member Services at the toll-free number on your ID card and request a copy.

P. Member Services

To file a compliant or an appeal, for additional information regarding copayments and other charges, information regarding benefits, to obtain copies of plan documents, information regarding how to file a claim or for any other question, you can contact

Member Services at the toll-free number on your ID card, or email us from your secure Aetna Navigator member website at **www.aetna.com**. Click on "Contact Us" after you log on.

Q. Privacy Notice

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

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

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

To request a printed 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 Legal Support Services Department
151 Farmington Avenue, W121
Hartford, CT 06156

You can also visit **www.aetna.com** and link directly to the Notice of Privacy Practices by selecting the "Privacy Notices" link at the bottom of the page.

R. Non-discrimination statement

Aetna does not discriminate in providing access to health care services on the basis of race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national origin. We are required to comply with Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, other laws applicable to recipients of federal funds, and all other applicable laws and rules.

S. Use of Race, Ethnicity and Language Data

Aetna members have the option to provide us with race/ethnicity and preferred language information. This information is voluntary and confidential. We collect this information to identify, research, develop, implement and/or enhance initiatives to improve health care access, delivery and outcomes for diverse members, and otherwise improve services to our members. We will maintain administrative, technical and physical safeguards to protect information concerning member race, ethnicity and language preference from inappropriate access, use or disclosure. This data will be collected, used or disclosed only in accordance with Aetna policies and applicable state and federal requirements. It is not used to determine eligibility, rating or claim payment.

For more information, please visit **www.aetna.com**. If you do not have Internet access and would like a hard copy of the information referenced here, please contact Member Services at the toll-free number on your ID card and request a copy.

T. Description of Benefits

1. Covered Benefits

A. Primary Care Physician Benefits

1. Office visits during office hours
2. Home visits/After-hours
3. Hospital visits
4. Periodic health evaluations to include:

a. well-child care from birth
b. routine physical examinations
c. routine gynecological examinations
d. routine hearing screenings
e. immunizations
f. routine vision screenings

Periodic health evaluations will be provided when medically necessary or at least as often as shown below:

Member's Age	Exam Frequency
0 - 1 year	1 exam every 4 months
2 - 5 years	1 exam every year
6 - 40 years	1 exam every 5 years
41 - 50 years	1 exam every 3 years
51 - 60 years	1 exam every 2 years
61 years and over	1 exam every year

Additionally, a medical history and health examination will be offered to each new member within 12 months after enrollment.

5. Injections, including allergy desensitization injections
6. Casts and dressings
7. Health education counseling and information

B. Diagnostic Services Benefits

Services include the following:

1. Diagnostic, laboratory, and X-ray services
2. Mammograms

Screening mammogram benefits for female members are provided as follows:

- age 35 through 39, one baseline mammogram;
- age 40 and older, 1 routine mammogram every year; or
- when medically necessary.

C. Specialist Physician Benefits, including outpatient and inpatient services

D. Direct Access Specialist Benefits

The following services are covered without a referral when rendered by a participating provider.

- Routine gynecological examination(s)
- Direct access to gynecologists
- Routine eye examinations
- Preventive dental care for members under the age of 12. See your Summary of Benefits for plan applicability.

E. Maternity Care and Related Newborn Care Benefits

F. Inpatient Hospital and Skilled Nursing Facility Benefits

G. Transplants Benefits

H. Outpatient Surgery Benefits

I. Substance Abuse Benefits (inpatient/outpatient services for detoxification)

J. Mental Health Benefits

K. Emergency Care/Urgent Care Benefits

L. Outpatient Rehabilitation Benefits

M. Home Health Benefits

N. Hospice Benefits

O. Prosthetic Appliances Benefits

P. Injectable Medications Benefits

Q. Basic Infertility Services Benefits

R. Diabetes Services

S. Blood and Blood Plasma

T. Reconstructive Breast Surgery Services

U. Chiropractic Benefits

Depending on your employer's chosen plan of benefits, there may be other benefits added to your plan as riders.

2. See your attached Summary of Benefits for copayment information.
3. Services are covered outside the plan in the event of an emergency. See Emergency Care.

U. Renewability of Coverage

1. Termination of Subscriber Coverage

A. A subscriber's coverage will terminate for any of the following reasons:

1. Employment terminates
2. The Group Agreement terminates
3. The subscriber is no longer eligible as outlined on the Schedule of Benefits

4. The subscriber becomes covered under an alternative health benefit plan or under any other plan which is offered by, through, or in connection with the contract holder in lieu of coverage under the COC

2. Termination of Dependent Coverage

A. A covered dependent's coverage will terminate for any of the following reasons:

1. A covered dependent is no longer eligible, as outlined on the Schedule of Benefits
2. The Group Agreement terminates
3. The subscriber's coverage terminates

3. Termination For Cause

A. We may terminate coverage for cause upon 60 days written notice:

1. If the member has failed to make any required premium payment that the member is obligated to pay. Upon the effective date of such termination, prepayments that we receive on account of such terminated member or members for periods after the effective date of termination shall be refunded to contract holder.
2. Upon discovering a material misrepresentation by the contract holder in applying for or obtaining coverage or benefits or discovering that the contract holder has committed fraud against Aetna.

V. Exclusions and Limitations that Apply to Services and Benefits

A. Exclusions

This section lists some, but not all, benefits and services that are not covered services under the COC. Members are advised to carefully review the entire COC, including the covered benefits section, and any applicable riders, to determine the extent of a particular benefit's coverage. The following are some, but not all, examples of limitations and excluded services and supplies for which a member is not covered under the COC:

- Ambulance services, for routine transportation to receive outpatient or inpatient services
- Beam neurologic testing
- Biofeedback, except as preauthorized by Aetna
- Blood and blood plasma, including provision of blood, blood plasma, blood derivatives, synthetic blood or blood products other than blood derived clotting factors, the collection or storage of blood plasma, the cost of receiving the services of professional blood donors, apheresis or plasmapheresis. Only administration, processing of blood, processing fees, and fees related to autologous blood donations are covered
- Care for conditions that state or local laws require to be treated in a public facility, including mental illness commitments
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury
- Cosmetic surgery, or treatment relating to the consequences of, or as a result of, cosmetic surgery, other than medically necessary services. This exclusion includes surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty, except when determined to be medically necessary by an Aetna medical director, is not covered. This exclusion does not apply to surgery to correct the results of injuries causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including cleft lip and cleft palate, and postmastectomy reconstruction.
- Costs for services resulting from the commission of or attempt to commit a felony by the member
- Court ordered services or those required by court order as a condition of parole or probation
- Custodial care
- Dental services, including services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, dental services related to the gums, apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, alveolectomy, augmentation and vestibuloplasty treatment of periodontal disease, false teeth, prosthetic restoration of dental implants, and dental implants. This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors, and orthodontogenic cysts.
- Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, learning disabilities, or developmental delays. Special education, including lessons in sign language to instruct a member, whose ability to speak has been

lost or impaired, to function without that ability, is not covered.

- Experimental or investigational procedures, or ineffective surgical, medical, psychiatric, or dental treatments or procedures, research studies, or other experimental or investigational health care procedures or pharmacological regimens as determined by Aetna, unless preauthorized by Aetna.

This exclusion will not apply with respect to drugs:

1. that have been granted treatment investigational new drug (IND) or Group c/treatment IND status;
2. that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or
3. We have determined that available scientific evidence demonstrates that the drug is effective or the drug shows promise of being effective for the disease.

This exclusion will also not apply to the following:

(Note: We will provide coverage for all medically necessary routine patient care costs incurred as a result of a treatment being provided in accordance with a cancer clinical trial in which a member participates voluntarily, except to the extent that the expenses are paid by the government, biotechnical, pharmaceutical or medical device industry sources.)

All of the following apply to a course of treatment for a cancer clinical trial:

1. The treatment is part of a scientific study of a new therapy or intervention that is being conducted at an institution in Arizona for the treatment, palliation or prevention of cancer in humans
2. The treatment is provided as part of a study being conducted in a phase I, phase II, phase III or phase IV cancer clinical trial
3. The treatment is provided as part of a study being conducted in accordance with a clinical trial approved by at least one of the following:
   a) One of the National Institutes of Health (NIH)
   b) An NIH cooperative group or center
   c) The U.S. Food and Drug Administration (FDA) in the form of an investigational new drug application
   d) The U.S. Departments of Defense and Veterans Affairs
   e) A panel of qualified recognized experts in clinical research within academic health institutions in Arizona
   f) A qualified research entity that meets the criteria established by the NIH for grant eligibility
4. The proposed treatment or study has been reviewed and approved by an institutional review board of an institution in Arizona
5. The personnel providing the treatment or conducting the study are doing so within their scope of practice, experience and training and are capable of providing the treatment because of their experience, training and volume of patients treated to maintain expertise
6. There is no clearly superior, noninvestigational treatment alternative
7. The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as any noninvestigational alternative

- Hair analysis
- Hearing aids
- Home births
- Home uterine activity monitoring
- Household equipment, including the purchase or rental of exercise cycles, water purifiers, hypoallergenic pillows, mattresses or waterbeds, whirlpool or swimming pools, exercise and massage equipment, central or unit air conditioners, air purifiers, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a member's house or place of business, and adjustments made to vehicles
- Hypnotherapy, except when preauthorized by Aetna
- Implantable drugs
- The treatment of male or female Infertility including:
  1. The purchase of donor sperm and any charges for the storage of sperm
  2. The purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers
  3. Charges associated with cryopreservation or storage of cryopreserved embryos (e.g., office, Hospital, ultrasounds, laboratory tests)
  4. Home ovulation prediction kits
  5. Injectable infertility medications, including menotropins, hCG, GnRH agonists, and IVIG

6. Artificial insemination, in vitro fertilization (IVF), gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), and intracytoplasmic sperm injection (ICSI), and any other advanced reproductive technology (ART) procedures or services related to such procedures
7. Any charges associated with care required for ART (e.g., office, Hospital, ultrasounds, laboratory tests)
8. Donor egg retrieval or fees associated with donor egg programs, including fees for laboratory tests
9. Any charges associated with a frozen embryo transfer, including thawing charges
10. Reversal of sterilization surgery
11. Any charges associated with obtaining sperm for any ART procedures

- Military service related diseases, disabilities or injuries for which the member is legally entitled to receive treatment at government facilities and which facilities are reasonably available to the member
- Missed appointment charges
- Nonmedically necessary services, including those services and supplies:
  1. That are not medically necessary, as determined by Aetna, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services
  2. That do not require the technical skills of a medical, mental health or dental professional
  3. Furnished mainly for the personal comfort or convenience of the member, or any person who cares for the member, or any person who is part of the member's family, or any provider
  4. Furnished solely because the member is an inpatient on any day in which the member's disease or injury could safely and adequately be diagnosed or treated while not confined
  5. Furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting
- Orthotics except when applied to diabetes-related care, supplies and treatment
- Outpatient supplies, including outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings, and reagent strips. This exclusion does not apply to diabetes-related care, supplies and treatment.
- Payment for that portion of the benefit for which Medicare or another party is the primary payer
- Personal comfort or convenience items, including those services and supplies not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other like items and services
- Prescription or nonprescription drugs and medicines, except when applied to diabetes-related care, supplies and treatment
- Private duty or special nursing care, unless preauthorized by Aetna
- Recreational, educational, and sleep therapy, including any related diagnostic testing
- Rehabilitation services, for substance abuse, including treatment of chronic alcoholism or drug addiction
- Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling, and sex therapy
- Reversal of voluntary sterilizations, including related follow-up care and treatment of complications of such procedures
- Routine foot/hand care, including routine reduction of nails, calluses and corns
- Services for which a member is not legally obligated to pay in the absence of this coverage
- Services for the treatment of sexual dysfunctions or inadequacies, including therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis
- Services, including those related to pregnancy, rendered before the effective date or after the termination of the member's coverage, unless coverage is continued under the Continuation and Conversion section of the COC
- Services performed by a relative of a member for which, in the absence of any health benefits coverage, no charge would be made
- Services required by third parties, including physical examinations and immunizations, except when medically necessary or indicated, and diagnostic procedures, in connection with:

1. obtaining or continuing employment;
2. securing insurance coverage; or
3. school admissions or attendance, including examinations required to participate in athletics, except when such examinations are considered to be part of an appropriate schedule of wellness services.

- Services that are not a covered benefit under the COC, even when a prior referral has been issued by a PCP
- Specific nonstandard allergy services and supplies, including skin titration (wrinkle method), cytotoxicity testing (Bryan's Test), treatment of nonspecific candida sensitivity, and urine autoinjections
- Specific injectable drugs, except when applied to diabetes-related care, supplies and treatment, including:
  1. experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the FDA and the NIH;
  2. needles, syringes and other injectable aids;
  3. drugs related to the treatment of noncovered services; and
  4. drugs related to the treatment of infertility, contraception, and performance-enhancing steroids.
- Special medical reports, including those not directly related to treatment of the member, e.g., employment or insurance physicals, and reports prepared in connection with litigation
- Surgical operations, procedures or treatment of obesity, except when preauthorized by Aetna
- Therapy or rehabilitation, including primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, vision perception training, and carbon dioxide
- Thermograms and thermography
- Transsexual surgery, sex change or transformation, including any procedure or treatment or related service designed to alter a member's physical characteristics from the member's biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems
- Treatment in a federal, state, or governmental entity, including care and treatment provided in a nonparticipating Hospital owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws
- Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded members in accordance with the benefits provided in the Covered Benefits section of the COC.
- Treatment of occupational injuries and occupational diseases, including those injuries that arise out of (or in the course of) any work for pay or profit, or in any way results from a disease or injury which does. If a member is covered under a Workers' Compensation law or similar law, and submits proof that the member is not covered for a particular disease or injury under such law, that disease or injury will be considered "nonoccupational" regardless of cause.
- Unauthorized services, including any service obtained by or on behalf of a member without a referral issued by the member's PCP or preauthorized by Aetna. This exclusion does not apply in a medical emergency, in an urgent care situation, or when it is a direct access benefit.
- Vision care services and supplies except as provided in the Description of Benefits
- Weight reduction programs, or dietary supplements
- Acupuncture and acupuncture therapy, except when performed by a participating physician as a form of anesthesia in connection with covered surgery
- Durable Medical Equipment, except when applied to diabetes-related care, supplies and treatment
- Family planning services
- Temporomandibular joint disorder treatment (TMJ), including treatment performed by prosthesis placed directly on the teeth, surgical and nonsurgical medical and dental services, and diagnostic or therapeutics services related to TMJ

B. Limitations.

- In the event there are two or more alternative medical services that, in the sole judgment of Aetna, are equivalent in quality of care, we reserve the right to provide coverage only for the least costly medical service, as determined by us, provided that we preauthorize the medical service or treatment
- Determinations regarding eligibility for benefits, coverage for services, benefit denials and all other terms of the COC are at the sole discretion of Aetna, subject to the terms of the COC.

W. Sample Summary of Benefits

Aetna Health Inc.
Arizona
Aetna HMO and Quality Point of Service Plans

PLAN FEATURES	In-Network (Referred Coverage)
FINANCIAL	
Maximum Out of Pocket	$1,500-Individual/$3000-Family
Plan Deductible: Individual / Family Limit	$100-Individual/$300-Family
Coinsurance	N/A
Coinsurance Limit: Single / Family	N/A
Lifetime Maximum Benefit	N/A
PHARMACY DEDUCTIBLE Individual / Family Limit	N/A
PHYSICIAN (PCP) OFFICE VISITS	
Office Hours	$25 copay
After Hours / Home Visits	$30 copay
SPECIALTY CARE	
Office Visits	$25 copay
Diagnostic Outpatient Lab / X-rays / Testing *(At facility)*	$25 copay with PCP referral
Diagnostic Outpatient Lab / X-rays / Testing *(At specialist)*	Included in Specialist Office Visit copay for visit with PCP referral
Outpatient Therapy *(Physical, occupational or speech)*	$25 copay; Treatment over a 60-day consecutive period per incident of illness or injury beginning with the first day of treatment
Outpatient Dialysis/Chemotherapy	$25 copay
Allergy Testing/Treatment	$25 copay for testing. $25 copay for allergy injection in PCP office. No serum copay.
PREVENTIVE CARE	
Routine Physicals	$25 copay
Routine Child and Well Baby Care; Including immunizations	$25 copay
Routine GYN Care	$25 copay. One routine GYN visit and pap smear/365 days. Direct access to participating providers
Routine Mammography	$25 copay; One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over.
Routine Eye Exam	$25 copay. Direct access to participating providers; Frequency and Age Schedules may apply
Hearing Exam	$25 copay. Routine hearing screenings.
Hearing Aids	Not covered
EMERGENCY ROOM *(Copay waived if admitted)*	$200 copay
URGENT CARE	$200 copay
AMBULANCE *(Not covered as routine transportation)*	No Copay
OUTPATIENT SURGERY	$50 copay
INPATIENT HOSPITAL SERVICES	$100 copay

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THE PLAN'S EVIDENCE OF COVERAGE SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

PLAN FEATURES	In-Network (Referred Coverage)
SKILLED NURSING FACILITY *(in lieu ofhospitalization for medically necessary covered benefits)*	$100 copay
MATERNITY	
First Ob/Gyn Visit	$25 copay for initial visit only.
Inpatient Hospital Services	$100 copay
HOME HEALTH CARE	No Copay
PRIVATE DUTY or SPECIAL DUTY NURSING	Not covered unless pre-authorized by HMO; no copay when covered
HOSPICE - INPATIENT	$100 copay
HOSPICE - OUTPATIENT	No copay
FAMILY PLANNING/REPRODUCTIVE SERVICES Sterilization Procedures	Covered with applicable specialist, outpatient surgery or inpatient hospital copay. Reversal of voluntary sterilization including related follow-up care and treatment of complications of such procedures is not covered.
MENTAL HEALTH	
Inpatient *(30 days per calendar year)*	$100 copay
Outpatient *(20 visits per calendar year)*	$25 copay
SUBSTANCE ABUSE DETOXIFICATION	
Inpatient Detoxification	$100 copay
Outpatient Detoxification	$25 copay
SUBSTANCE ABUSE REHABILITATION	
Inpatient *(30 days per calendar year)*	$100 copay
Outpatient *(20 visits per calendar year)*	$25 copay
DIABETIC SUPPLIES	RX copay if RX rider purchased; otherwise PCP copay applies
CHIROPRACTIC CARE	$25 copay; Limited to 20 visits per calendar year No PCP referral needed. Requires direct access to medically necessary chiropractic services
DURABLE MEDICAL EQUIPMENT	No copay
PRESCRIPTION DRUG RIDER	$10 copay generic formulary; $30 copay brand formulary; $60 copay generic and brand non-formulary; up to 30 day supply
No Mandatory Generics	generic and brand non-formulary; up to 30 day supply.
ADDITIONAL PHARMACY OPTIONS	31 - 90 day supply included for Mail Order Delivery (MOD) - 2 times the 30 day supply. Open formulary - Covers drugs on the formulary exclusion list.
Contraceptive Option	Included in Prescription Drug Option
Performance Option	Included in Prescription Drug Option
DENTAL	Not Covered
VISION CORRECTIVE LENSES/CONTACTS ALLOWANCE	Not Covered
ADVANCED REPRODUCTIVE TECHNOLOGY Available In-network only to groups with 500+ employees	Not Covered
MEDICAL SPENDING FUND Individual/Family Limits	Not Available

What's Not Covered
Exclusions and Limitations

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Blood and blood byproducts, except as administered on an inpatient or emergency care basis.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval.
- Durable Medical Equipment.
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Hearing aids.
- Home births.
- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectible drugs including injectible infertility drugs.
- Infertility services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services unless specifically listed as covered in your plan documents.
- Long-term rehabilitation therapy.
- Nonmedically necessary services or supplies.
- Orthotics except when applied to Diabetes-related care, supplies and treatment.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies, counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Treatment of behavioral disorders.

In Arizona, benefits are provided by Aetna Health Inc. for HMO plans.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. 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 Schedule of Benefits, Certificate of Coverage, 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. Some benefits are subject to limitations or visit maximums. Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law. Certain primary care providers are affiliated with integrated delivery systems or other provider groups (such as independent practice associations and physician-hospital organizations), and members who select these providers will generally be referred to specialists and hospitals within those systems or groups. However, if a system or group does not include a provider qualified to meet member's medical needs, member may request to have services provided by non-system or non-group providers. Member's request will be reviewed and will require prior authorization from the system or group and/or Aetna to be a covered benefit. While this material is believed to be accurate as of the print date, it is subject to change.

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THE PLAN'S EVIDENCE OF COVERAGE SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

Aetna Health Inc.
Administered by Aetna Health Insurance Company
Arizona
Quality Point of Service (QPOS) Out-of-Network Benefits

PLAN FEATURES	Out-of-Network (Non-Referred Coverage)
FINANCIAL	
Maximum Out of Pocket	
Plan Deductible: Individual / Family Limit	$300-Individual/$900-Family
Coinsurance	60%
Coinsurance Limit: Single / Family	$4,000-Individual/$8,000-Family
Lifetime Maximum Benefit	$1,000,000
PHYSICIAN (PCP) OFFICE VISITS	
Office Hours	60% after deductible
After Hours / Home Visits	60% after deductible
SPECIALTY CARE	
Office Visits	60% after deductible
Diagnostic Outpatient Lab / X-rays / Testing *(At facility)*	60% after deductible
Diagnostic Outpatient Lab / X-rays / Testing *(At specialist)*	60% after deductible
Outpatient Therapy *(Physical, occupational or speech)*	60% after deductible
Outpatient Dialysis/Chemotherapy	60% after deductible
Allergy Testing/Treatment	60% after deductible
PREVENTIVE CARE	
Routine Physicals	Not covered unless optional preventive care rider is purchased.
Routine Child and Well Baby Care; Including immunizations	Not covered unless optional preventive care rider is purchased.
Routine GYN Care	Not covered unless optional preventive care rider is purchased.
Routine Mammography	60% after deductible; One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over.
Routine Eye Exam	Not covered
Hearing Exam	60% after deductible for illness or injury.
Hearing Aids	Not covered
EMERGENCY ROOM *(Copay waived if admitted)*	$200 copay
URGENT CARE	60% after deductible
AMBULANCE (Not covered as routine transportation)	No Copay
OUTPATIENT SURGERY	60% after deductible
INPATIENT HOSPITAL SERVICES	60% after deductible
SKILLED NURSING FACILITY	60% after deductible
(in lieu of hospitalization for medically necessary covered benefits)	240 days and 35 physician visits per calendar year
MATERNITY	
First Ob/Gyn Visit	60% after deductible
Inpatient Hospital Services	60% after deductible

THIS DISCLOSURE FORM IS ONLY A SUMMARY.
THE PLAN'S EVIDENCE OF COVERAGE SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

PLAN FEATURES	Out-of-Network (Non-Referred Coverage)
HOME HEALTH CARE	60% after deductible
PRIVATE DUTY or SPECIAL DUTY NURSING	60% after deductible (Same limitations as In-Network)
HOSPICE - INPATIENT	60% after deductible $10,000 lifetime maximum on Combined Inpatient and Outpatient
HOSPICE - OUTPATIENT	60% after deductible $10,000 lifetime maximum on Combined Inpatient and Outpatient
FAMILY PLANNING/REPRODUCTIVE SERVICES Sterilization Procedures	60% after deductible. Certain services are covered. Same limitations as In-Network.
MENTAL HEALTH	
Inpatient *(30 days per calendar year)*	60% after deductible
Outpatient *(20 visits per calendar year)*	50% after deductible
SUBSTANCE ABUSE DETOXIFICATION	
Inpatient Detoxification	60% after deductible
Outpatient Detoxification	60% after deductible
SUBSTANCE ABUSE REHABILITATION	
Inpatient *(30 days per calendar year)*	Not Covered
Outpatient *(20 visits per calendar year)*	Not Covered
DIABETIC SUPPLIES	60% after deductible
CHIROPRACTIC CARE	60% after deductible
DURABLE MEDICAL EQUIPMENT	60% after deductible Must pre-certify if over $1,500
PRESCRIPTION DRUG RIDER ***No Mandatory Generics***	No coverage 31 - 90 day supply included for Mail Order Delivery (MOD) - 2 times the 30 day supply. Open formulary - Covers drugs on the formulary exclusion list.
ADDITIONAL PHARMACY OPTIONS	
Contraceptive Option	Not Covered
Performance Option	Not Covered
DENTAL	Not Covered
VISION CORRECTIVE LENSES/CONTACTS ALLOWANCE	Not Covered
ADVANCED REPRODUCTIVE TECHNOLOGY Available In-network only to groups with 500+ employees	Not Covered
MEDICAL SPENDING FUND Individual/Family Limits	Not Available

What's Not Covered
Exclusions and Limitations

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Blood and blood byproducts, except as administered on an inpatient or emergency care basis.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval.
- Durable Medical Equipment.
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Hearing aids.
- Home births.
- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectible drugs including injectible infertility drugs.
- Infertility services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services unless specifically listed as covered in your plan documents.
- Long-term rehabilitation therapy.
- Nonmedically necessary services or supplies.
- Orthotics except when applied to Diabetes-related care, supplies and treatment.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies, counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Treatment of behavioral disorders.

Quality Point-of-Service benefits are provided and or administered by Aetna Health Inc. and/or Corporate Health Insurance Company.

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Limitations

In the event there are two or more alternative Medical Services which in the sole judgment of CHI are equivalent in quality of care, CHI reserves the right to provide coverage only for the least costly Medical Service, as determined by CHI, provided that CHI approves coverage for the Medical Service or treatment in advance.

QPOS referred benefits may be provided or administered by: Aetna Health Inc. Inc., and/or Corporate Health Insurance Company.

This material is intended for distribution only to employers and other plan sponsors.

Specific products may not be available in both self-funded and insured forms.

For any service or supply that is subject to a maximum limitation, such maximums will be reduced by any services or supplies which are covered as referred or non-referred benefits under a point-of-service program. Benefit limits offset and do not duplicate each other.

THIS DISCLOSURE FORM IS ONLY A SUMMARY.
THE PLAN'S EVIDENCE OF COVERAGE SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

Aetna Health Inc.
Arizona
Aetna Open Access Plan

Referrals are not required for a member to access in-network, covered services. Preauthorization for certain services is required. The Primary Care Physician Office Visit (PCP) copay pertains only to a member's selected PCP; the applicable specialist copay applies to any other participating physician office visits.

PLAN FEATURES	In-Network
FINANCIAL	
Maximum Out of Pocket	$1,500-Individual/$3000-Family
Plan Deductible: Individual / Family Limit	$100-Individual/$300-Family
Coinsurance	N/A
Coinsurance Limit: Single / Family	N/A
Lifetime Maximum Benefit	N/A
PHARMACY DEDUCTIBLE Individual / Family Limit	N/A
PHYSICIAN (PCP) OFFICE VISITS	
Office Hours	$25 copay
After Hours / Home Visits	$30 copay
SPECIALTY CARE	
Office Visits	$25 copay
Diagnostic Outpatient Lab / X-rays / Testing *(At facility)*	$25 copay
Diagnostic Outpatient Lab / X-rays / Testing *(At specialist)*	Included in Specialist Office Visit copay
Outpatient Therapy *(Physical, occupational or speech)*	$25 copay; Treatment over a 60-day consecutive period per incident of illness or injury beginning with the first day of treatment
Outpatient Dialysis/Chemotherapy	$25 copay
Allergy Testing/Treatment	$25 copay for testing. $25 copay for allergy injection in PCP office. No serum copay.
PREVENTIVE CARE	
Routine Physicals	$25 copay
Routine Child and Well Baby Care; Including immunizations	$25 copay
Routine GYN Care	$25 copay. One routine GYN visit and pap smear/365 days. Direct access to participating providers
Routine Mammography	$25 copay; One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over.
Routine Eye Exam	$25 copay. Direct access to participating providers; Frequency and Age Schedules may apply
Hearing Exam	$25 copay. Routine hearing screenings.
Hearing Aids	Not covered
EMERGENCY ROOM	$200 copay
URGENT CARE	$100 copay
AMBULANCE *(Not covered as routine transportation)*	No Copay
OUTPATIENT SURGERY	$50 copay

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PLAN FEATURES	In-Network
INPATIENT HOSPITAL SERVICES	$100 copay
SKILLED NURSING FACILITY *(in lieu of hospitalization for medically necessary covered benefits)*	$100 copay
MATERNITY	
First Ob/Gyn Visit	$25 copay for initial visit only.
Inpatient Hospital Services	$100 copay
HOME HEALTH CARE	No Copay
PRIVATE DUTY or SPECIAL DUTY NURSING	Not covered unless pre-authorized by HMO; no copay when covered
HOSPICE - INPATIENT	$100 copay
HOSPICE - OUTPATIENT	No copay
FAMILY PLANNING/REPRODUCTIVE SERVICES Sterilization Procedures	Covered with applicable specialist, outpatient surgery or inpatient hospital copay. Reversal of voluntary sterilization including related follow-up care and treatment of complications of such procedures is not covered.
MENTAL HEALTH	
Inpatient *(30 days per calendar year)*	$100 copay
Outpatient *(20 visits per calendar year)*	$25 copay
SUBSTANCE ABUSE DETOXIFICATION	
Inpatient Detoxification	$100 copay
Outpatient Detoxification	$25 copay
SUBSTANCE ABUSE REHABILITATION	
Inpatient *(30 days per calendar year)*	$100 copay
Outpatient *(20 visits per calendar year)*	$25 copay
DIABETIC SUPPLIES	RX copay if RX rider purchased; otherwise PCP copay applies
CHIROPRACTIC CARE	$25 copay; Limited to 20 visits per calendar year No PCP referral needed. Requires direct access to medically necessary chiropractic services
DURABLE MEDICAL EQUIPMENT	No copay
PRESCRIPTION DRUG RIDER ***No Mandatory Generics***	$10 copay generic formulary; $30 copay brand formulary; $60 copay generic and brand non-formulary; up to 30 day supply. 31 - 90 day supply included for Mail Order Delivery (MOD) - 2 times the 30 day supply. Open formulary - Covers drugs on the formulary exclusion list.
ADDITIONAL PHARMACY OPTIONS	
Contraceptive Option	Included in Prescription Drug Option
Performance Option	Included in Prescription Drug Option
DENTAL	Not Covered
VISION CORRECTIVE LENSES/CONTACTS ALLOWANCE	Not Covered
ADVANCED REPRODUCTIVE TECHNOLOGY Available In-network only to groups with 500+ employees	Not Covered
MEDICAL SPENDING FUND Individual/Family Limits	Not Available

What's Not Covered
Exclusions and Limitations

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Blood and blood byproducts, except as administered on an inpatient or emergency care basis.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval.
- Durable Medical Equipment.
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Hearing aids.
- Home births.
- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectible drugs including injectible infertility drugs.
- Infertility services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services unless specifically listed as covered in your plan documents.
- Long-term rehabilitation therapy.
- Nonmedically necessary services or supplies.
- Orthotics except when applied to Diabetes-related care, supplies and treatment.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies, counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Treatment of behavioral disorders.

In Arizona, benefits are provided by Aetna Health Inc. for HMO plans.

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Aetna Health Inc.
Arizona
Aetna Choice POS Plan

Referrals are not required for a member to access in-network, covered services. Preauthorization for certain services is required. The Primary Care Physician Office Visit (PCP) copay pertains only to a member's selected PCP; the applicable specialist copay applies to any other participating physician office visits.

PLAN FEATURES	In-Network
FINANCIAL	
Maximum Out of Pocket	$1,500-Individual/$3000-Family
Plan Deductible: Individual / Family Limit	N/A
Coinsurance	N/A
Coinsurance Limit: Single / Family	N/A
Lifetime Maximum Benefit	N/A
PHARMACY DEDUCTIBLE Individual / Family Limit	N/A
PHYSICIAN (PCP) OFFICE VISITS	
Office Hours	$25 copay
After Hours / Home Visits	$30 copay
SPECIALTY CARE	
Office Visits	$25 copay
Diagnostic Outpatient Lab / X-rays / Testing *(At facility)*	$25 copay
Diagnostic Outpatient Lab / X-rays / Testing *(At specialist)*	Included in Specialist Office Visit copay
Outpatient Therapy *(Physical, occupational or speech)*	$25 copay; Treatment over a 60-day consecutive period per incident of illness or injury beginning with the first day of treatment
Outpatient Dialysis/Chemotherapy	$25 copay
Allergy Testing/Treatment	$25 copay for testing. $25 copay for allergy injection in PCP office. $0 serum copay.
PREVENTIVE CARE	
Routine Physicals	$25 copay
Routine Child and Well Baby Care; Including immunizations	$25 copay
Routine GYN Care	$25 copay. One routine GYN visit and pap smear/365 days. Direct access to participating providers
Routine Mammography	$25 copay; One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over.
Routine Eye Exam	$25 copay. Direct access to participating providers; Frequency and Age Schedules may apply
Hearing Exam	$25 copay. Routine hearing screenings.
Hearing Aids	Not covered
EMERGENCY ROOM	$200 copay
URGENT CARE	$200 copay
AMBULANCE *(Not covered as routine transportation)*	No Copay

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PLAN FEATURES	In-Network
OUTPATIENT SURGERY	$50 copay
INPATIENT HOSPITAL SERVICES	$100 copay
SKILLED NURSING FACILITY *(in lieu of hospitalization for medically necessary covered benefits)*	$100 copay
MATERNITY	
First Ob/Gyn Visit	$25 copay for initial visit only.
Inpatient Hospital Services	$100 copay
HOME HEALTH CARE	No Copay
PRIVATE DUTY or SPECIAL DUTY NURSING	Not covered unless pre-authorized by HMO; no copay when covered
HOSPICE - INPATIENT	$100 copay
HOSPICE - OUTPATIENT	No copay
FAMILY PLANNING/REPRODUCTIVE SERVICES Sterilization Procedures	Covered with applicable specialist, outpatient surgery or inpatient hospital copay. Reversal of voluntary sterilization including related follow-up care and treatment of complications of such procedures is not covered.
MENTAL HEALTH	
Inpatient *(30 days per calendar year)*	$100 copay
Outpatient *(20 visits per calendar year)*	$25 copay
SUBSTANCE ABUSE DETOXIFICATION	
Inpatient Detoxification	$100 copay
Outpatient Detoxification	$25 copay
SUBSTANCE ABUSE REHABILITATION	
Inpatient *(30 days per calendar year)*	$100 copay
Outpatient *(20 visits per calendar year)*	$25 copay
DIABETIC SUPPLIES	RX copay if RX rider purchased; otherwise PCP copay applies
CHIROPRACTIC CARE	$25 copay; Limited to 20 visits per calendar year No PCP referral needed. Requires direct access to medically necessary chiropractic services
DURABLE MEDICAL EQUIPMENT	No copay
PRESCRIPTION DRUG RIDER ***No Mandatory Generics***	$10 copay generic formulary; $30 copay brand formulary; $60 copay generic and brand non-formulary; up to 30 day supply. 31 - 90 day supply included for Mail Order Delivery (MOD) - 2 times the 30 day supply.Open formulary - Covers drugs on the formulary exclusion list.
ADDITIONAL PHARMACY OPTIONS	
Contraceptive Option	Included in Prescription Drug Option
Performance Option	Included in Prescription Drug Option
DENTAL	Not Covered
VISION CORRECTIVE LENSES/CONTACTS ALLOWANCE	Not Covered
ADVANCED REPRODUCTIVE TECHNOLOGY Available In-network only to groups with 500+ employees	Not Covered
MEDICAL SPENDING FUND Individual/Family Limits	Not Available

What's Not Covered
Exclusions and Limitations

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Blood and blood byproducts, except as administered on an inpatient or emergency care basis.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval.
- Durable Medical Equipment.
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Hearing aids.
- Home births.
- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectible drugs including injectible infertility drugs.
- Infertility services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services unless specifically listed as covered in your plan documents.
- Long-term rehabilitation therapy.
- Nonmedically necessary services or supplies.
- Orthotics except when applied to Diabetes-related care, supplies and treatment.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies, counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Treatment of behavioral disorders.

Aetna Choice POS is provided by Aetna Health Inc. and/or Aetna Health Insurance Company.

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Aetna Health Inc.
Administered by Aetna Health Insurance Company
Arizona
Aetna Choice POS Out Of Network Benefits

PLAN FEATURES	Out-of-Network*
FINANCIAL	
Plan Deductible: Individual / Family Limit	$100-Individual/$300-Family
Coinsurance Benefit paid by plan	60%
Coinsurance Limit: Single / Family	$5,000-Individual/$15,000-Family
Lifetime Maximum Benefit	$1,000,000
PRIMARY CARE PHYSICIAN VISITS (for illness and injury only)	
Office Hours	60% after deductible
After Hours / Home Visits	60% after deductible
SPECIALTY CARE	
Office Visits	60% after deductible
Diagnostic Outpatient Lab / X-rays / Testing *(At facility)*	60% after deductible
Diagnostic Outpatient Lab / X-rays / Testing *(At specialist)*	60% after deductible
Outpatient Therapy *(Physical, occupational or speech)*	60% after deductible. Treatment over a 60-day consecutive period per incident of illness or injury beginning with the first day of treatment.
Outpatient Dialysis/Chemotherapy	60% after deductible
Allergy Testing/Treatment	60% after deductible
PREVENTIVE CARE	
Routine Physicals	Not covered unless optional preventive care rider is purchased.
Routine Child and Well Baby Care; Including immunizations	Not covered unless optional preventive care rider is purchased.
Routine GYN Care	Not covered unless optional preventive care rider is purchased.
Routine Mammography	60% after deductible; One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over.
Routine Eye Exam	Not covered
Hearing Exam	60% after deductible for illness or injury.
Hearing Aids	Not covered
EMERGENCY CARE	(Same as In-Network Coverage)
URGENT CARE FACILITY	60% after deductible
AMBULANCE *(Not covered as routine transportation)*	(Same as In-Network Coverage)
OUTPATIENT SURGERY	60% after deductible
HOSPITALIZATION	60% after deductible
SKILLED NURSING FACILITY	60% after deductible
(in lieu of hospitalization for medically necessary covered benefits)	240 days and 35 physician visits per calendar year
MATERNITY	
First Ob/Gyn Visit	60% after deductible
Inpatient Hospital Services	60% after deductible
HOME HEALTH CARE	60% after deductible

PRIVATE DUTY or SPECIAL DUTY NURSING	60% after deductible (Same limitations as In-Network)
HOSPICE - INPATIENT	60% after deductible $10,000 lifetime maximum on Combined Inpatient and Outpatient
HOSPICE - OUTPATIENT	60% after deductible $10,000 lifetime maximum on Combined Inpatient and Outpatient
FAMILY PLANNING/REPRODUCTIVE SERVICES	60% after deductible.
Sterilization Procedures	Certain services are covered. Same limitations as In-Network.
MENTAL HEALTH	
Inpatient *(30 days per calendar year)*	60% after deductible
Outpatient *(20 visits per calendar year)*	50% after deductible
SUBSTANCE ABUSE DETOXIFICATION	
Inpatient Detoxification	60% after deductible
Outpatient Detoxification	60% after deductible
SUBSTANCE ABUSE REHABILITATION	
Inpatient *(30 days per calendar year)*	Not Covered
Outpatient *(20 visits per calendar year)*	Not Covered
DIABETIC SUPPLIES	60% after deductible
CHIROPRACTIC CARE	60% after deductible
DURABLE MEDICAL EQUIPMENT	60% after deductible Must pre-certify if over $1,500
OUT-OF-NETWORK ALL PREVENTIVE CARE RIDER *(excluding mandated benefits)*	No coverage

What's Not Covered
Exclusions and Limitations

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- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval.
- Durable Medical Equipment.
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Hearing aids.
- Home births.
- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectible drugs including injectible infertility drugs.
- Infertility services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services unless specifically listed as covered in your plan documents.
- Long-term rehabilitation therapy.
- Nonmedically necessary services or supplies.

- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies, counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Treatment of behavioral disorders.

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Limitations

In the event there are two or more alternative Medical Services which in the sole judgment of CHI are equivalent in quality of care, CHI reserves the right to provide coverage only for the least costly Medical Service, as determined by CHI, provided that CHI approves coverage for the Medical Service or treatment in advance.

QPOS and USAccess referred benefits may be provided or administered by: Aetna Health Inc. and/or Corporate Health Insurance Company.

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Specific products may not be available in both self-funded and insured forms.

For any service or supply that is subject to a maximum limitation, such maximums will be reduced by any services or supplies which are covered as referred or non-referred benefits under a point-of-service program. Benefit limits offset and do not duplicate each other.

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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.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

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

Request for Certificate of Creditable Coverage

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

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, coverage will be provided to a person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy for:

(1) reconstruction of the breast on which a mastectomy has been performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;

(3) prostheses; and

(4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

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If you require language assistance from an Aetna representative, please call the Member Services number located on your ID card, and you will be connected with the language line if needed; or you may dial direct at 1-888-982-3862 (140 languages are available. You must ask for an interpreter).
TDD 1-800-628-3323 (hearing impaired only).

Si requiere la asistencia de un representante de Aetna que hable su idioma, por favor llame al número de Servicios al Miembro que aparece en su tarjeta de identificación y se le comunicará con la línea de idiomas si es necesario; de lo contrario, puede llamar directamente al 1-888-982-3862 (140 idiomas disponibles. Debe pedir un intérprete). TDD-1-800-628-3323 (sólo para las personas con impedimentos auditivos).