Appeal Information Packet and Other Important Disclosure Information Arizona

Health Care Insurer Appeals Process Information Packet - Aetna Life 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 (602) 912-8444 or 1 (800) 325-2548, or you may call us at the Member Services number printed on your Member ID card.

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 "reasonable charge." Where applicable, a 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 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 the Member Services 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. Telephone: (602) 255-4421.

Who Can File an Appeal

Either you or your treating provider, on your behalf, can file an appeal. 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 he/she can help you with the information needed 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)
Level 1. - Expedited Medical Review
Level 2. - Expedited Appeal
Level 3. - Expedited External, Independent Medical Review

Standard Appeals
(For non-urgent services or denied claims)
Level 1. - Informal Reconsideration
Level 2. - Formal Appeal
Level 3. - External, Independent Medical Review

We make the appeal decisions at Level 1 and Level 2. An outside reviewer, who is completely independent from our company, makes Level 3 appeal decisions. You are not responsible to pay the costs of the external review if you choose to appeal to Level 3. These three levels of Appeal are discussed in detail below:

Expedited Appeal Process For Urgently Needed Services Not Yet Provided

Expedited Medical Review (Level 1)

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 in writing and provides supporting documentation that the time required to process your request through the Informal Reconsideration and Formal Appeal process (about 60 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 self made form with similar information.) Your treating provider must send the certification and documentation to:

Name:	Aetna Life Insurance Company Attn: Medical Resolution Team
Address:	P.O. Box 14596 Lexington, KY 40512
Phone:	800-305-7342
Fax:	818-932-6566

Our Decision: We have 1 business day after we receive the information from the treating provider to decide whether we should change our decision and authorize your requested service. Within that same business day, we must call and inform you and your treating provider of our decision. We will then mail our written decision 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 2.

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

If we refer your case to Level 3: We may decide to skip the Level 1 and Level 2 expedited appeal process and send your case directly to an independent reviewer at Level 3.

Expedited Appeal (Level 2)

Your request: If we deny your request at Level 1, Expedited Medical Review you may request an Expedited Appeal. After you receive our Level 1 denial, your treating provider must immediately send us a written request (to the same person and address listed above under Level 1) to tell us you are appealing to Level 2, Expedited Appeal. To help your appeal, your provider should also send us any additional information that hasn't already been sent to show why you need the requested service.

Our decision: We have 3 business days after we receive the request to make our decision.

If we deny your request: You may immediately appeal to Level 3, Expedited External, Independent Medical Review.

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

If we refer your case to Level 3: We may decide to skip the Level 2, Expedited Appeal and send your case directly to an independent reviewer at Level 3.

Expedited External, Independent Review (Level 3)

Your request: You may appeal to Level 3 only after you have appealed through Levels 1 and 2 of the expedited appeal process. You have only 5 business days after you receive our Level 2, Expedited Appeal decision to send us your written request for Expedited External Independent Review. Send your request and any more supporting information to:

Name:	Aetna Life Insurance Company Attn: Medical Resolution Team
Address:	P.O. Box 14596 Lexington, KY 40512
Phone:	800-305-7342
Fax:	818-932-6566

Neither you nor your treating provider is responsible for the cost of any external independent review.

The process: There are two types of Level 3 appeals, depending on the issues in your case:

(1) Medical Necessity

These are cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for are not medically necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization ("IRO"), that has contracted with the Arizona Insurance Department, and not connected with our company. The IRO provider must be a provider who typically manages the condition under review.

(2) Contract Coverage

These are cases where we have denied coverage because we believe the requested service is not covered under your insurance policy. For contract coverage cases, the Arizona Insurance Department is the independent reviewer.

Medical Necessity Cases

Within 1 business day of receiving your request, we must:

1. Mail a written acknowledgement of the request to the Director of Insurance, you, and your treating provider.
2. Send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; 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 clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

Within 2 business days of receiving our information, the Insurance Director must send all the submitted information to an external independent review 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 us, you, and your treating provider.

The decision (medical necessity): 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 process is complete. Your only further option is to pursue your claim in Superior Court.

Contract Coverage Cases

Within 1 business day of receiving your request, we must:

1. Mail a written acknowledgement of your request to the Insurance Director, you, and your treating provider.
2. Send the Director of Insurance: the request for review, your policy, evidence of coverage or similar document; 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 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 us, you, and your treating provider.

Referral to the IRO for contract coverage cases: The Insurance Director is sometimes unable to determine issues of coverage. If this occurs, the Insurance Director will forward your 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 us, you, and your treating provider.

The decision (contract coverage): If you disagree with the Insurance Director's final decision on a contract coverage issue, you 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 Director's decision. OAH must promptly schedule and complete a hearing for appeals from expedited Level 3 decisions.

Standard Appeal Process For Non-Urgent Services and Denied Claims

Informal Reconsideration (Level 1)

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 denied the requested service or claim by calling, writing, or faxing your request to:

Name:	Aetna Life Insurance Company Attn: Medical Resolution Team
Address:	P.O. Box 14596 Lexington, KY 40512
Phone:	800-305-7342
Fax:	818-932-6566

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 30 days after the receipt date to decide whether we should change our decision and authorize your requested service or pay your claim. Within that same 30 days, 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: You have 60 days to appeal to Level 2, Formal Appeal.

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 3: We may decide to skip Level 1 and Level 2 standard appeal process and send your case directly to an independent reviewer at Level 3.

Formal Appeal (Level 2)

Your request: You may request a Formal Appeal if we denied your request or claim at Level 1. After you receive our Level 1, Informal Reconsideration denial, you or your treating provider must send us a written request within 60 days to tell us you are appealing to a Level 2, Formal Appeal. To help us make a decision on your appeal, you or your provider should also send us any additional information (that you haven't already sent us) to show why we should authorize the requested service or pay the claim. Send your appeal request and information to:

Name:	Aetna Life Insurance Company Attn: Medical Resolution Team
Address:	P.O. Box 14596 Lexington, KY 40512
Phone:	800-305-7342
Fax:	818-932-6566

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 30 days after the receipt date to decide whether we should change our decision and authorize your requested service. For denied claims, even though we have up to 60 days to decide whether we should change our decision and pay your claim, we aim to decide such matters within 30 days. 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 or claim: You have 30 days to appeal to Level 3, External, Independent Medical Review.

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 3: We may decide to skip the Level 2, Formal Appeal and send your case directly to an independent reviewer at Level 3.

External, Independent Review (Level 3)

Your request: You may appeal to Level 3 only after you have appealed through Levels 1 and 2 of the Standard Appeal process. You have 30 days after you receive our Level 2 decision to send us your written request for External Independent Review. Send your request and any more supporting information to:

Name:	Aetna Life Insurance Company Attn: Medical Resolution Team
Address:	P.O. Box 14596 Lexington, KY 40512
Phone:	800-305-7342
Fax:	818-932-6566

Neither you nor your treating provider is responsible for the cost of any external independent review.

The process: There are two types of Level 3 appeals, depending on the issues in your case:

(1) Medical Necessity
These are cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for, are not medically necessary to treat your problem. For medical necessity cases, the 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 our company. For medical necessity cases, the IRO provider must be a provider who typically manages the condition under review.

(2) Contract Coverage
These are cases where we have denied coverage because we believe the requested service is not covered under your insurance policy. For contract coverage cases, the Arizona Insurance Department is the independent reviewer.

Medical Necessity Cases

Within 5 business days of receiving your request, we must:

1. Mail a written acknowledgement of the request to the Director of Insurance, you, and your treating provider.
2. Send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; 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 clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

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

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

Within 5 business days of receiving the IRO's decision, the Insurance Director must mail a notice of the decision to us, you, and your treating provider.

The decision (medical necessity): If the IRO decides that we should provide the service or pay the claim, we must authorize the service or pay the claim. If the IRO agrees with our decision to deny the service or payment, the appeal process is complete. Your only further option is to pursue your claim in Superior Court.

Contract Coverage Cases

Within 5 business days of receiving your request, we must:

1. Mail a written acknowledgement of your request to the Insurance Director, you, and your treating provider.
2. Send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; 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 Insurance Director must determine if the service or claim is covered, issue a decision, and send a notice to us, you, and your treating provider. If the Director decides that we should provide the service or pay the claim, we must do so.

Referral to the IRO for contract coverage cases: The Insurance Director is sometimes unable to determine issues of coverage. If this occurs, the Insurance Director will forward your case to an IRO. The IRO will have 21 days to make a decision and send it to the Insurance Director. The Insurance Director will have 5 business day after receiving the IRO's decision to send the decision to us, you, and your treating provider.

The decision (contract coverage): If you disagree with Insurance Director's final decision on a contract coverage issue, you 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. The OAH has rules that govern the conduct of its hearing proceedings.

II. Obtaining Medical Records

Arizona law (A.R.S. §12-2293) permits you to ask for a copy of your medical records. Your request must be in writing and must specify who you want to receive the records. The health care provider who has your records will provide you or the person you specified with a copy of your records.

Designated Decision-Maker: If you have a designated health care decision-maker, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your health care decision-maker or a person designated in writing by your health care decision-maker unless you limit access to your medical records only to yourself or your health care decision-maker.

Confidentiality: Medical records disclosed under A.R.S. §12-2293 remain confidential. If you participate in the appeal process, the relevant portions of your 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 your medical information to any other people.

III. Documentation for an Appeal

If you decide to file an appeal, you must give us any material justification or documentation for the appeal at the time the appeal is filed. If you gather new information during the course of your appeal, you should give it to us as soon as you get it. You must also give us the address and phone number where you can be contacted. If the appeal is already at Level 3, you should also send the information to the Department.

IV. The Role of the Director of Insurance

Arizona law (A.R.S. §20-2533(F)) requires "any member who files a complaint with the Department relating to an adverse decision to pursue the review process prescribed" by law. This means, that for decisions that may be appealed, you must pursue the health care appeals process before the Insurance Director can investigate a complaint you may have against our company 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 insurers.
3. Receive, process, and act on requests from an insurer for External, Independent Review.
4. Enforce the decisions of insurers.
5. Review decisions of insurers.
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.

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 on the fifth business day after being mailed. "Properly addressed," means your last known address.

We want you to know℠

Aetna®

Once you have completed this Form, submit to:

Aetna Life Insurance Company
Medical Resolution Team
P.O. Box 14596
Lexington, KY 40512
Fax: 818-932-6566

Health Care 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 to 60 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

(602) 912-8444 or 1 (800) 325-2548

You may also call the Aetna Member Services number on the member's ID card.

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

We want you to know℠

Aetna®

Once you have completed this Form, submit to:
Aetna Life Insurance Company
Medical Resolution Team
P.O. Box 14596
Lexington, KY 40512
Fax: 818-932-6566

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 60 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 #_____ FAX #_____

Address_____

City_____ State_____ Zip Code_____

INSURER INFORMATION

Insurers 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 (602) 912-8444 or 1 (800) 325-2548. You may also call Aetna Member Services number on the member's ID card.

I certify, as the patient's treating provider, that delaying the patient's care for the time period needed for the informal reconsideration and formal appeal processes (about 60 days) is likely to cause a significant negative change in the patient's medical condition at issue.

Provider's Signature_____**Date**_____

Combined Small and Large Group Disclosure Form

Aetna Life Insurance Company (Aetna)

Please read this notice carefully.
This notice contains important information you should know before you enroll.

This Disclosure form is only a summary.

Aetna's policy, certificate or evidence of coverage should be consulted to determine governing contractual provisions.

A. Aetna's Primary Care Physicians Roster

See the attached Directory for a list of Primary Care Physicians (PCPs). The Directory shows each physician's degree, practice specialty, and year initially licensed to practice in Arizona.

B. Premium

The full monthly premium cost is shown on the attached premium form.

The full monthly premium cost of the plan is:

Employee only	$_____
Employee & spouse	$_____
Employee & children	$_____
Family	$_____

The portion of the premium paid by you will depend on the amount of your employer's contribution.

Aetna reserves the right to change premium rates upon the plan's anniversary date, as well as require changes in the employer contributions or participation levels to comply with the published underwriting requirements. Aetna also reserves the right to change premium rates prior to the plan's anniversary date should the enrolled membership, employer contribution levels, and/or participation levels significantly change during the policy period from when these rates are effective. A minimum of 60-day notification will be provided by Aetna prior to any premium rate change.

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 upon 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, industry, and group size. They may not include claims experience, health status, or duration of coverage.

The rates for your group may be adjusted at the commencement of any rating period based upon your group's claims experience, health status, 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 rate or 75% of the employee-only rate.

Participation requirements: Less than 4 eligible employees require a minimum of 100% participation, excluding valid benefit waivers. 4 or more employees require a minimum of 75% participation, excluding valid benefit waivers.

C. How and Where to Obtain Services

Traditional Choice® is an indemnity fee-for-service medical plan that gives you the freedom to choose any recognized physician or hospital whenever you need medical treatment for covered services. You are not required to select a PCP for benefit purposes and no referrals are necessary. Certain expenses, including but not limited to nonemergency inpatient hospital care, require precertification. You precertify by calling Aetna. Failure to precertify may result in substantially reduced benefits.

Open Choice® is a preferred provider plan. You can go directly to any recognized provider for covered services, including specialists. No referrals are required.

- If you choose a provider from our network of participating (preferred) physicians and hospitals, your out-of-pocket costs will be lower.
- If you choose a physician or hospital outside of the network, your out-of-pocket costs will be higher, except for emergency treatment.

Managed Choice® POS is a point-of-service plan. You can choose to access benefits in one of two ways:

- You can minimize your out-of-pocket costs by visiting the primary care physician (PCP) you selected and obtaining referrals, when necessary, from your PCP.
- You also have the option to access any recognized provider (in or out of network) without a referral, for covered services, but your out-of-pockets costs will be higher, except emergency treatment and direct access benefits.

Aetna Open Access® is a point-of-service plan. You can access covered services one of three ways each time you seek care.

- You can go to your selected PCP and pay a lower copay, or
- You can go directly to any network (preferred) physician and pay a higher copay, or
- You can go directly to any licensed non-network physician and incur high out-of-pocket costs when you pay a deductible and a coinsurance amount (up to a maximum).

Aetna's network for Open Choice, Managed Choice and Open Access plans includes providers in the following counties: Apache, Cochise, Coconino, Gila, Graham, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai and Yuma.

D. Preauthorization and Referral Procedures

Role of Primary Care Physicians

For some plans, you are required or encouraged to select a PCP who participates in the network. The PCP can provide primary care as well as coordinate your overall care. You should consult your PCP when you are sick or injured to help determine the care that is needed. Under Managed Choice, your PCP should issue referrals to participating specialists and facilities for certain services. For some services, the PCP is required to obtain prior authorization from Aetna.

Referral Policy

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

- The referral is how your PCP arranges for you to be covered for necessary, appropriate specialty care and follow-up treatment.
- You should discuss the referral with your PCP to understand what specialist services are being recommended and why.
- If the specialist recommends any additional treatments or tests that are covered services, you may need to get another referral from your PCP prior to receiving the services. If you do not get another referral for these services, you may be responsible for payment.
- Except in emergencies, all hospital admissions and outpatient surgery require a prior referral from your PCP and prior approval by Aetna.
- If it is not an emergency and you go to a physician 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.
- Under Managed Choice, coverage for services from nonparticipating providers requires prior approval by Aetna in addition to a special nonparticipating referral from the PCP. When properly authorized, these services are fully covered, less the applicable copay.
- The referral provides that, except for applicable copay, the member will not have to pay the charges for covered services, as long as the individual is a member at the time the services are provided.

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

Direct Access Ob/Gyn Program
Female plan members have direct access to participating Ob/Gyns for covered obstetric and gynecologic services, eliminating the need for referrals. 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.

Behavioral Health Network
Certain behavioral health care services (e.g., treatment or care for mental disease or illness, alcohol abuse and/or substance abuse) are managed by an independently contracted organization. This organization makes initial coverage determinations and coordinates referrals; any behavioral health care referrals will generally be made to providers affiliated with the organization, unless your needs for covered services extend beyond the capability of the affiliated providers.

You can receive information regarding the appropriate way to access the behavioral health care services that are covered under your specific plan by calling the Behavioral Health toll-free number on your ID card. As with other coverage determinations, you may appeal behavioral health care coverage decisions in accordance with the provisions of your health plan or applicable state law.

Precertification and Necessary Services
Precertification is the process of collecting information prior to inpatient admissions and performance of selected ambulatory procedures and services. The process permits advance eligibility verification, determination of coverage, and communication with the physician and/or member. It also allows Aetna to coordinate the patient's transition from the inpatient setting to the next level of care (discharge planning), or to register patients for specialized programs like disease management, case management, or our prenatal program. In some instances, precertification is used to inform physicians, members and other health care providers about cost-effective programs and alternative therapies and treatments.

Certain health care services, such as hospitalization or outpatient surgery, require precertification with Aetna to ensure coverage for those services. When a member is to obtain services requiring precertification through a participating provider, this provider should precertify those services prior to treatment. If your plan covers out-of-network benefits and you may self-refer for covered services, it is your responsibility to contact Aetna to precertify those services, which require precertification.

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

To be appropriate, 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 person's overall health condition;
- be a diagnostic procedure, indicated by the health status of the person 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 person's overall health condition; 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 alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration information provided on the affected person's health status:

- reports in peer-reviewed medical literature;
- reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered to be necessary:

- those that do not require the technical skills of a medical, a mental health or a dental professional; or
- those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any health care provider or health care facility; or

- those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- those 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.

To request precertification, you must call the number shown on your ID card. Such precertification must be obtained before care is received, or in the case of an emergency admission, procedure or treatment, within 48 hours after the start of a confinement as a full-time inpatient or the performance of the procedure or treatment, (72 hours if the confinement starts or if the procedure or treatment is performed on a Friday or Saturday), or as soon as reasonably possible.

Utilization Review/Patient Management
Aetna has developed a patient management program to assist in determining what health care services are covered and payable under the health plan and the extent of such coverage and payment. The program assists members in receiving appropriate health care and maximizing coverage for those health care services.

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

Where such use is appropriate, our utilization review/patient management staff uses nationally recognized guidelines and resources, such as Milliman Care Guidelines™ and InterQual® ISD® criteria, to guide the precertification, concurrent review and retrospective review processes. To the extent certain utilization review/patient management functions are delegated to integrated delivery systems, independent practice associations or other provider groups ("Delegates"), such Delegates utilize criteria that they deem appropriate. Utilization review/patient management policies may be modified to comply with applicable state law.

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

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

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

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

E. Emergency Care

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

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

Call the local emergency hotline (ex. 911) or go to the nearest emergency facility. If a delay would not be detrimental to your health, call your PCP. Notify your PCP as soon as possible after receiving treatment.

If you are admitted to an inpatient facility, you or a family member or friend on your behalf should notify your PCP or Aetna within 48 hours of the start of the confinement as a full-time inpatient (72 hours if the confinement starts on a Friday or Saturday) or as soon as reasonably possible.

F. Prescription Drugs

If your plan covers outpatient prescription drugs, your plan may include a drug formulary. A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan subject to applicable limitations and conditions. The medications listed on the formulary are subject to change in accordance with applicable state law. For information regarding how medications are reviewed and selected for the formulary, please refer to the Aetna Medication Formulary Guide. A printed copy of the Formulary Guide will be provided, upon request or, if applicable, annually for current members and upon enrollment for new members. Additional copies can be obtained by calling Member Services at the toll-free number listed on your member ID card, and current Formulary Guide information is available by accessing our website at www.aetna.com. Many drugs listed on the formulary are subject to manufacturer rebate arrangements between Aetna and the manufacturer of the drugs for the benefit of Aetna. Your pharmacy benefit is not limited to the drugs listed on the formulary. Medications that are not listed on the formulary may be covered subject to the limits and exclusions set forth in your plan documents. Covered prescription drugs not listed on the formulary may be subject to higher copays under some benefit plans. Some pharmacy benefit plans may exclude certain drugs not listed on the formulary from coverage. If it is medically necessary for members enrolled in these benefit plans to use such drugs, their physicians (or pharmacist in the case of antibiotics and analgesics) may contact Aetna to request coverage as a medical exception. You may be required to pay the difference in cost between a covered brand-name drug and its generic equivalent in addition to your copay, depending on the benefit plan selected by your employer. Check your plan documents for details. In addition, certain drugs may require precertification or step therapy under some prescription drug benefit plans. Step therapy is a different form of precertification 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 a member to use a medication subject to these requirements, the member's physician can request coverage of such drug as a medical exception. Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and conditions of coverage.

If you use the mail-order prescription program of Aetna Rx Home Delivery, LLC, you will be acquiring these prescriptions through an affiliate of Aetna Inc.

G. Complaint Procedures

Filing a Complaint or Appeal

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

If you are dissatisfied with the outcome of your initial contact, you may file an appeal. If you are not satisfied after filing a formal appeal, you may request a second-level appeal of the decision. Your appeal will be decided in accordance with the procedures applicable to your plan and applicable state law. Refer to your plan documents for further details regarding your plan's appeal procedure.

External Review

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

An external review organization will refer the case to review by an independent physician with appropriate expertise in the area in question. After all necessary information is submitted, an external review generally will be decided within 30 calendar days of the request. Expedited reviews are available when a member's physician certifies that a delay in service would jeopardize the member's health. Once the review is complete, the plan will abide by the decision of the external reviewer.

Certain states mandate external review of additional benefit or service issues; some may require a filing fee. In addition, certain states mandate the use of their own external review process for medical necessity and experimental/investigational coverage decisions. These state mandates may not apply to self-funded plans. For further details regarding your plan's grievance and external review process, call the Member Services toll-free number on your ID card or visit our website at www.aetna.com where you may obtain an external review request form. You also may call your state insurance or health department or consult their website for additional information regarding state-mandated external review procedures.

H. Company Provider Requirements and Compensation

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

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

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

Participating providers have no requirement to comply with specified numbers, targeted averages or maximum durations for patient visits.

There are no plan compensation incentives or penalties that are intended to encourage providers to withhold services or to minimize or avoid referrals to specialists.

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

Claims Payment for Nonparticipating Providers and Use of Claims Software

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

I. Description of Benefits-Renewability of Coverage

The health care benefits and any copayments, coinsurance or deductibles for your plan are shown on the attached Plan Design & Benefits form attached.

The initial term of the plan is usually for a period of one year. Each subsequent term will be for a period of one year unless the plan terminates as provided for in the group policy. Aetna may change premiums under the plan as of any renewal date upon 30 days prior written notice.

J. Limitations and Exclusions that Apply to Services and Benefits

This plan does not cover all health care expenses and includes exclusions and limitations. You should refer to your 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*.

- All medical and hospital services not specifically covered in or which are limited or excluded by your plan documents.
- Charges related to any eye surgery mainly to correct refractive errors.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval.
- Experimental and investigational procedures.
- Hearing aids.
- Immunizations for travel or work.
- 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.
- Nonmedically necessary services or supplies.
- Orthotics.
- Over-the-counter medications and supplies.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling.
- Special duty nursing.

K. 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 a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

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

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

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

Health Insurance Portability and Accountability Act Member Notice*

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

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

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

Creditable Coverage

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

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

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

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

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

Providing Proof of Creditable Coverage

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

You may request a Certification of Prior Group Health Plan Coverage from your prior carrier(s) with whom you had coverage within the past two years. Our Service Center can assist you with this and can provide you with the type of information that you will need to request from your prior carrier.

The Service Center may also request information from you regarding any pre-existing condition for which you may have been treated in the past and other information that will allow them to determine if you have creditable coverage.

* While this member notice is believed to be accurate as of the print date, it is subject to change. Please contact the Member Services Department if you have any questions.

Special Enrollment Periods

Due to Loss of Coverage

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

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

- When you declined enrollment for you or your dependent, you stated in writing that coverage under another group health plan or other health insurance was the reason for declining enrollment, if the employer required such written notice and you were given notice of the requirement and the consequences of not providing the statement; and
- When you declined enrollment for you or your dependent, you or your dependent had COBRA continuation coverage under another plan and that COBRA continuation coverage has since been exhausted,

  or

  If the other coverage that applied to you or your dependent when enrollment was declined was not under a COBRA continuation provision, either the other coverage has been terminated as a result of the loss of eligibility or employer contributions toward that coverage have been terminated. Loss of eligibility includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, or reduction in hours of employment.

For Certain Dependent Beneficiaries

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

Special Enrollment Rules

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

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

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

Special Enrollment Rights

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

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

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

Request for Certificate of Creditable Coverage

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

*While this Member Notice is believed to be accurate as of the publication date, it is subject to change. Please contact the Member Services department if you have any questions.

Notes

Notes

Notes

Notice to Members

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

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee any results or outcomes. Consult the plan documents [Booklet, Booklet-certificate, Group Policy] to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan. The availability of a plan or program may vary by geographic service area. Some benefits are subject to limitations or visit maximums.

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

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

Plans are provided by Aetna Life Insurance Company.