

**AETNA HEALTH OF CALIFORNIA INC (AETNA)
[HMO, Aetna HealthFund® HMO, QPOS®, PrimeCare Physicians Plan, Aetna Value
NetworkSM, Vitalidad Mexico con AetnaSM, Vitalidad PlusSM]**

2625 SHADELANDS DRIVE
WALNUT CREEK, CA 94598

IMPORTANT CONSUMER DISCLOSURE INFORMATION

THIS DISCLOSURE FORM IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE CONTAINS THE TERMS AND CONDITIONS OF COVERAGE AND SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

PLEASE READ THIS DISCLOSURE FORM FULLY AND CAREFULLY. IT CONTAINS IMPORTANT INFORMATION YOU SHOULD KNOW BEFORE YOU ENROLL. INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS SHOULD CAREFULLY READ THOSE SECTIONS THAT APPLY TO THEM.

THE EVIDENCE OF COVERAGE DISCLOSES THE TERMS AND CONDITIONS OF COVERAGE. YOU HAVE THE RIGHT TO VIEW THE EVIDENCE OF COVERAGE BEFORE YOU ENROLL. YOU MAY REQUEST A SPECIMEN COPY OF THE EVIDENCE OF COVERAGE FROM YOUR EMPLOYER GROUP OR BY CONTACTING AETNA AT **1-888-257-3241**.

THE INFORMATION WHICH FOLLOWS PROVIDES GENERAL INFORMATION REGARDING AETNA HEALTH® PLANS. YOU SHOULD REFER TO YOUR SPECIFIC PLAN DOCUMENTS FOR ADDITIONAL INFORMATION REGARDING THE OPERATION OF YOUR PLAN. ADDITIONAL IMPORTANT INFORMATION REGARDING:

- YOUR PRIMARY CARE PHYSICIAN (PCP),
- PARTICIPATING PROVIDERS
- REFERRALS AND AUTHORIZATION,
- REQUESTING CONTINUITY OF CARE OR STANDING REFERRALS,
- FACILITIES, AND
- GRIEVANCE PROCEDURES

THEY MAY BE FOUND IN THE SAMPLE EVIDENCE OF COVERAGE (EOC) WHICH WILL BE PROVIDED TO YOU UPON REQUEST. INFORMATION ABOUT HOW AETNA DETERMINES MEDICAL NECESSITY MAY BE FOUND AT THE BEGINNING OF THE "COVERED BENEFITS" SECTION OF THE SAMPLE EOC.

IN CASES WHERE THERE IS A CONFLICT BETWEEN THE GROUP CONTRACT AND THE EOC, THE EOC WILL PREVAIL.

YOU CAN FIND ADDITIONAL INFORMATION, INCLUDING PROVIDER DIRECTORIES, THE PRESCRIPTION DRUG FORMULARY, COVERAGE POLICY BULLETINS AND OTHER IMPORTANT INFORMATION, AT OUR WEBSITE, **WWW.AETNA.COM**. YOU CAN CONTACT THE CALIFORNIA DEPARTMENT OF MANAGED CARE AT **HTTP://WWW.HMOHELP.CA.GOV**

PRINCIPAL BENEFITS AND COVERAGES.

Benefits are provided for many of the medically necessary services and supplies needed for care and treatment of sickness and injuries or to maintain good health. Not all services and supplies are covered, some are covered only to a limited extent and some require precertification and referrals. Aetna referred benefits must be provided by or accessed through your selected primary care physician. Principal Services and Supplies for which benefits are provided include:

- Primary care physician (PCP) benefits for: Office and hospital visits; Periodic health evaluations, including well child care, immunizations, routine physical examinations, routine gynecological examinations, and routine cancer, hearing and vision screenings; Injections, including allergy desensitization injections; casts and dressings; and health education counseling and information.
- Diagnostic, laboratory and x-ray services.
- Specialist physician visits including outpatient and inpatient services.
- Direct access specialists visits for: routine gynecological visits and for diagnosis and treatment of gynecological problems; and routine eye examinations.
- Maternity care and related newborn care.
- Inpatient hospital and skilled nursing facility care.
- Non-experimental and non-investigational transplants.
- Outpatient surgery.
- Substance abuse care (inpatient/outpatient services for detoxification).

[Drafting Note: For use when Federal Mental Health Parity Law of 2008 applies:

- Mental health care.]
- Pervasive Developmental Disorders or autism is covered as **Severe Mental Illness** and/or **Serious Emotional Disturbances of a Child**. Treatment includes, but is not limited to, physical, occupational and speech therapy.

[Drafting Note: For use when Federal Mental Health Parity Law of 2008 does not apply:

- Mental health care for severe mental illness and serious emotional disturbances of a child.]
- Pervasive Developmental Disorders or autism is covered as **Severe Mental Illness** and/or **Serious Emotional Disturbances of a Child**. Treatment includes, but is not limited to, physical, occupational and speech therapy.
- Emergency and urgent care services.
- Outpatient rehabilitation services including: cardiac and pulmonary rehabilitation; and cognitive, physical, occupational, and speech therapy.
- Home health and hospice care.
- Prosthetic and orthotic appliances.
- Mastectomy and reconstructive breast surgery.
- Other reconstructive surgery.
- Limited general anesthesia for dental procedures.
- Diabetes treatment
- Phenylketonuria care.
- Temporomandibular joint syndrome procedures, except dental procedures.
- Covered Services and Supplies in connection with Clinical Cancer Trials.

Eligibility, covered benefits, medical necessity, precertification, concurrent review, retrospective record review and all other terms and conditions of your health plan are determined at the discretion of Aetna Health (or its designee). This means that some services recommended by your health professional may not be deemed covered benefits as determined by Aetna Health. Determinations are subject to review by the Department of Managed Health Care and under certain circumstances may be eligible for independent medical review also.

PRINCIPAL EXCLUSIONS AND LIMITATIONS ON BENEFITS.

EXCLUSIONS

The following is a list of services and supplies that are generally not covered.

- Cosmetic surgery.
- Custodial care. **Please Note:** A Member receiving custodial care is also entitled to receive **medically necessary** basic health care services.
- Dental care and dental x-rays.
- Donor egg retrieval.
- Experimental and investigational procedures. Please see the section Complaints and Appeals/Independent Medical Review, for information regarding your right to appeal and independent medical review for claims denied because they are considered experimental and investigational.
- Hearing aids.
- Home births.
- Implantable drugs and certain injectable drugs including injectable infertility drugs unless specifically listed as covered in the Evidence of Coverage.
- 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 the Evidence of Coverage.
- Non-medically necessary services and supplies.
- Orthotics, except as specified in the Evidence of Coverage.
- Outpatient prescription drugs and over-the-counter medications and supplies unless specifically listed as covered in the Evidence of Coverage.
- Radial keratotomy and related procedures.
- Reversal of sterilization.
- Special duty nursing.
- Rehabilitation Therapies when, pursuant to a written treatment plan, it is determined that the therapy is no longer medically necessary.

[Drafting Note: For use ONLY when Federal Mental Health Parity Law of 2008 does NOT apply:

- Treatment of behavioral disorders, except severe mental illness for members of all ages and serious emotional disturbances of a child.]

LIMITATIONS

If two or more alternative medical services which in the sole judgment of Aetna are equivalent in quality of care, Aetna reserves the right to provide coverage only for the least costly medical service. Determination by Aetna that two or more alternative medical services are equivalent is a decision regarding medical necessity and therefore subject to Independent Medical Review. Please see the section Complaints and Appeals/Independent Medical Review, for information regarding your right to appeal and to independent medical review for claims denied, limited or delayed due to medical necessity. Determinations regarding eligibility for benefits, coverage for services, benefit denials and all other terms of the Evidence of Coverage are at the discretion of Aetna.

SOME HOSPITALS AND OTHER PROVIDERS DO NOT PROVIDE ONE OR MORE OF THE FOLLOWING SERVICES THAT MAY BE COVERED UNDER YOUR PLAN CONTRACT THAT YOU OR YOUR FAMILY MEMBER MIGHT NEED:

- **Family planning.**
- **Contraceptive services, including emergency contraception.**
- **Sterilization, including tubal ligation at the time of labor and delivery.**
- **Infertility treatment.**
- **Abortion.**

YOU SHOULD OBTAIN MORE INFORMATION BEFORE YOU ENROLL. CALL YOUR PROSPECTIVE DOCTOR, MEDICAL GROUP, INDEPENDENT PRACTICE ASSOCIATION, OR CLINIC TO ENSURE THAT YOU CAN OBTAIN THE HEALTH CARE SERVICES THAT YOU NEED. PLEASE CALL MEMBER SERVICES AT 1-888-982-3862 FOR MORE INFORMATION ABOUT YOUR PLAN.

PREPAYMENT FEES

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

OTHER CHARGES

If your plan does not specifically cover self-referred or out-of-network 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 the Evidence of Coverage.

CHOICE OF PHYSICIANS AND PROVIDERS

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

[Your health care plan utilizes the [HMO, Aetna HealthFund HMO, QPOS, PrimeCare Physicians Plan, Aetna Value Network, Vitalidad Mexico con Aetna, Vitalidad Plus] provider network. Throughout this Disclosure Brochure, references to "Participating Providers" or "network" refer to providers and facilities in the [HMO, Aetna HealthFund HMO, QPOS, Aetna Value Network, SIMNSA Network for the Vitalidad Mexico con Aetna, Vitalidad Plus, PrimeCare Physicians Plan] network.

Providers may be contracted with Aetna Health under a different network, but are non-participating providers in relation to the [HMO, Aetna HealthFund HMO, QPOS, Aetna Value Network, SIMNSA Network for the Vitalidad Mexico con Aetna, Vitalidad Plus, PrimeCare Physicians Plan,] network. Throughout this Disclosure Brochure references to "Non-participating Providers" refers to providers and facilities not included in the [HMO, Aetna HealthFund HMO, QPOS, Aetna Value Network, SIMNSA Network for the Vitalidad Mexico con Aetna, Vitalidad Plus, PrimeCare Physicians Plan] network.

ROLE OF PRIMARY CARE PHYSICIANS ("PCPS")

For most HMO plans, members are required to select a PCP who participates in the network. The PCP can provide primary care as well as coordinate your overall care.

Members should consult their PCP when they are sick or injured to help determine the care that is needed. 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 plans that include benefits for nonparticipating provider services (QPOS), or in an emergency, members will need to obtain a referral authorization ("referral") from their PCP before seeking covered nonemergency specialty or hospital care. Check your plan documents for details.

Certain PCPs are affiliated with integrated delivery systems, independent practice associations ("IPAs") or other provider groups, and members who select these PCPs will generally be referred to specialists and hospitals within that system, association or group. However, if your medical needs extend beyond the scope of the affiliated providers, you may request coverage for services provided by non-affiliated network physicians and facilities. In order to be covered, services provided by non-affiliated network providers may require pre-approval from Aetna Health and/or the integrated delivery systems or other provider groups.

To find a primary care physician (PCP), go to our online provider directory, DocFind® located at www.aetna.com/docfind/custom/caprimecarephysicians.

DocFind is available 24 hours a day, 7 days a week and is updated three times a week. With DocFind's easy to use format, you can search for a provider online by name, specialty, gender and/or hospital affiliation. A printed directory is also available upon request.

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.

- The member should discuss the referral with their PCP to understand what specialist services are being recommended and why.
- If the specialist recommends any additional treatments or tests that are covered benefits, the member may need to get another referral from their PCP prior to receiving the services. If the member does not get another referral for these services, the member may be responsible for payment.
- Except in emergencies, all hospital admissions and outpatient surgery require a prior referral from the member's PCP and prior authorization by Aetna.
- If it is not an emergency and the member goes to a doctor or facility without a referral, the member must pay the bill.
- Referrals are valid for 60 days as long as the individual remains an eligible member of the plan.
- In plans without out-of-network benefits, coverage for services from non-participating providers requires prior authorization by Aetna in addition to a special non-participating 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, the member will not have to pay the charges for covered benefits, as long as the individual is a member at the time the services are provided.

You may also request a **Standing Referral** for certain degenerative and disabling conditions or diseases. Please consult your Evidence of Coverage for additional information.

NOT SURE WHAT KIND OF CARE YOU NEED? ACCESS TRIAGE AND SCREENING SERVICES

Sometimes it's difficult to know what kind of care you need, so we have licensed health care professionals available to assist you by phone 24 hours a day, seven days a week. Here are some of the ways they can help you:

- They can answer questions about a health concern, and instruct you on self-care at home if appropriate.
- They can advise you about whether you should get medical care, and how and where to get care (for example, if you are not sure whether your condition is an Emergency Medical Condition, they can help you decide whether you need Emergency Care or Urgent Care, and how and where to get that care).
- They can tell you what to do if you need care and a Plan Medical Office is closed.

You can reach one of these licensed health care professionals by calling the toll-free number listed on your ID card or your PCP at the number listed on your card. When you call, a trained support person may ask you questions to help determine how to direct your call.

DIRECT ACCESS

Under QPOS plans a member may directly access nonparticipating providers without a PCP referral, subject to 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 self-referred or nonparticipating provider 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

This program allows female members to visit any participating obstetrician or gynecologist for a routine well-woman exam, including a Pap smear, and for obstetric or gynecologic problems. Obstetricians and gynecologists may also refer a woman directly to other participating providers for covered obstetric or gynecologic services. All health plan preauthorization and coordination requirements continue to apply. If your Ob/Gyn is part of an Independent Practice Association (IPA), a Physician Medical Group (PMG), an Integrated Delivery System (IDS) or a similar organization, your care must be coordinated through the IPA, the PMG or similar organization and the organization may have different referral policies.

HEALTH CARE PROVIDER NETWORK

All hospitals may not be considered participating for all services. Your physician can contact Aetna to identify a participating facility for your specific needs. Certain PCPs are affiliated with integrated delivery systems, independent practice associations ("IPAs") or other provider groups, 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. These organizations or, their affiliated providers may be compensated by Aetna through a capitation arrangement or other global payment method. The organization then pays the

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

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, September 2010. (Available at <http://familydoctor.org/003.xml#printxml>)

TRANSPLANTS AND OTHER COMPLEX CONDITIONS

Our National Medical Excellence Program® and other specialty programs help eligible members access covered treatment for transplants and certain other complex medical conditions at participating facilities experienced in performing these services. Depending on the terms of your plan of benefits, members may be limited to only those facilities participating in these programs when needing a transplant or other complex condition covered.

BEHAVIORAL HEALTH NETWORK

Behavioral health care services are managed by Aetna. Aetna is 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. You can determine the type of behavioral health coverage available under the terms of their plan 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, you may access covered behavioral health services available under your health plan by the following methods:

- Call the toll-free Behavioral Health number (where applicable) on your ID card or, if no number is listed, call the Member Services number 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 pre-authorization. However, you should first consult with Member Services to confirm that any such outpatient therapy services do not require a referral or pre-authorization.

Behavioral Health Provider Safety Data Available

For information regarding our Behavioral Health provider network safety data, please go to www.aetna.com and review the quality and patient safety links posted: <http://www.aetna.com/docfind/quality.html#jcaho>. You may select the quality checks link for details regarding our providers' safety reports.

BEHAVIORAL HEALTH PREVENTION PROGRAMS

Aetna Behavioral Health offers two prevention programs for our members: Perinatal Depression Education, Screening and Treatment Referral Program and Identification and Referral of Adolescent Members Diagnosed With Depression Who Also Have Co-morbid 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.

REIMBURSEMENT PROVISIONS

The "Claims Procedures" section of the EOC explains how the Aetna complies with Federal Department of Labor (DOL) regulations for claim determinations and appeals, (CFR 29 2560). Additional California-specific information regarding complaints and appeals is provided in the Complaints and Appeals and Independent Medical Review sections which follow. The DOL Regulations define a claim as occurring whenever you or your authorized representative:

- requests pre-authorization as required by the plan;
- requests a referral as required by the plan from a Participating Provider;
- requests payment for services or treatment; or
- requests concurrent or retrospective utilization review.

If you receive a bill for covered benefits, the bill must be submitted promptly to Aetna for payment.

Send the itemized bill for payment with your identification number clearly marked to the address shown on your ID card, within 90 days of the date the covered benefit was received, unless it is not reasonably possible to do so. To be eligible for consideration as a covered benefit, the bill for any service or supply sought or received by you must be submitted to and received by Aetna no later than 12 months after the date the service was provided unless it can be shown that it was not reasonably possible to submit the bill and that the bill was submitted as soon as was reasonably possible.

Aetna will make a decision on the claim. For urgent care claims and pre-service claims, Aetna will send you a written notification of the determination.

FACILITIES

Participating provider offices and other health care facilities can be located through DocFind or by calling **1-800-756-7039**.

RENEWAL PROVISIONS

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 agreement. Aetna may change premiums under the plan as of any renewal date upon 30 days prior written notice.

Benefits may be modified during the term of the plan as specifically provided under the terms of the group agreement or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply for services or supplies furnished on or after the effective date of the modification. There is no vested right to receive the benefits of the plan.

ELIGIBILITY

References to "spouses" and "dependents" also include Domestic Partners and dependents of Domestic Partners. Verification of domestic partnership will only be required if the plan requests verification of marital status or dissolution of marriage for all plan members.

INDIVIDUAL CONTINUATION OF BENEFITS

Members may be entitled to continue coverage under certain circumstances when coverage would otherwise terminate. The Federal law pertaining to this continuation of benefits is the Consolidated Omnibus Reconciliation Act ("COBRA"). COBRA applies to employers with twenty (20) or more eligible employees. The California state law is the California Benefits Replacement Act ("Cal-COBRA"). Cal-COBRA applies to California small employers with fewer than twenty (20) eligible employees. Many of the provisions of COBRA and Cal-COBRA are the same.

COBRA and Cal-COBRA continuation coverage give employees and their dependents whose group plan would otherwise end the opportunity to continue the same group plan for a period of time, usually 18, 29 or 36 months for COBRA; 36 months for Cal-COBRA. Members who have exhausted continuation coverage under COBRA (if continuation coverage is for less than 36

months) have the opportunity to continue coverage for up to 36 months under Cal-COBRA. Employee members have this right if they lose their job or have working hours reduced (other than for gross misconduct). Dependent members also have this right to continued coverage if their member spouse dies or they get divorced, or cease to be a dependent child.

The Continuation of Coverage for Retired Subscribers and Spouses (also referred to as "Senior COBRA") will not be available for subscribers who reached the age of 60 after January 1, 2005.

Additional information regarding COBRA and Cal-COBRA may be found in your Evidence of Coverage.

A member who is totally disabled on the date the plan ends will have coverage continued for that disability. Coverage continuation will end at the earlier of: the member's disability ends, covered benefits are exhausted, member's coverage under another plan, or 12 months.

TERMINATION OF BENEFITS

Coverage may be terminated for nonpayment of premium. Termination will occur even if you are hospital confined or undergoing treatment for an ongoing condition. At least 15 days advance written notice of termination will be provided.

Coverage may also terminate for other reasons, including, but not limited to: terminating employment or losing group membership, obtaining coverage under an alternative health plan offered by the employer or group or moving out of the service area. If your coverage is terminated for fraud or material misrepresentation in enrollment or in the use of services or facilities, you will receive at least a 30-day written notice of termination.

RIGHT TO REQUEST REVIEW OF RESCISSION, CANCELLATION OR NONRENEWAL OF YOUR ENROLLMENT OR SUBSCRIPTION

If you believe that your health plan enrollment or subscription has been, or will be, improperly rescinded, canceled, or not renewed, you have the right to file a complaint. A complaint is also called a grievance or an appeal.

FIRST, FILE YOUR COMPLAINT WITH AETNA:

- You can file a complaint with *Aetna* by calling 1-800-843-3661 or visiting www.aetna.com.
- You should file your complaint as soon as possible after you receive notice that your health plan enrollment or subscription will be rescinded, canceled or not renewed.
- If your problem is urgent *Aetna* must give you a decision within 3 days. Your problem is urgent if there is a serious threat to your health that must be resolved quickly.
- If your problem is not urgent, *Aetna* must give you a decision within 30 days.

TAKE YOUR COMPLAINT TO THE CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE (DMHC):

The DMHC oversees HMOs and other health plans in California and protects the rights of HMO members. You can file a complaint with the DMHC if:

- You are not satisfied with *Aetna's* decision about your complaint, or;
- You have not received the decision within 30 days or within 3 days if the problem is urgent.
- The DMHC may allow you to submit a complaint directly to the DMHC, even if you have not filed a complaint with your health plan, if the DMHC determines that your problem requires immediate review.

An optional DMHC complaint form is available at www.healthhelp.ca.gov.

FOR HELP CONTACT:

**Help Center, DMHC
980 Ninth St., Suite 500
Sacramento, CA 95814-2725
1-888-466-2219
TDD: 1-877-688-9891
FAX: 1-916-255-5241
www.healthhelp.ca.gov**

There is no charge to call. Help is available in many languages.

COMPLAINTS AND APPEALS/INDEPENDENT MEDICAL REVIEW

Aetna is committed to addressing members' coverage issues, complaints and problems. If you have a coverage issue or other problem, contact Member Services by calling the Member Services toll-free number on your ID card, or write to Member Services at the following:

AETNA HEALTH OF CALIFORNIA INC.
ATTN: MEDICAL RESOLUTION TEAM
PO BOX 10169
VAN NUYS, CA 91410

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 proficient in the English language, you should call our Language Assistance Line at 1-877-287-0117 in order to obtain any applicable notices in your primary language that describe the Appeals Process for Internal and External Reviews.

DEPARTMENT OF MANAGED HEALTH CARE

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your plan, you should first call your health plan at **1-800-756-7039** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatment that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department has a **toll-free number, (1-888-HMO-2219)** and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The department's Internet website (<http://www.hmohelp.ca.gov>) has complaint forms, IMR application forms and instructions online.

BINDING ARBITRATION

Any dispute arising from or related to health plan membership will be determined by submission to binding arbitration, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. The agreement to arbitrate includes, but is not limited to, disputes involving alleged professional liability or medical malpractice, that is whether any medical services covered by the plan were unnecessary or were unauthorized or were improperly, negligently or incompetently rendered. This agreement also limits certain remedies and may limit the award of punitive damages. You understand that you are giving up your constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration. See Sections Binding Arbitration and Limitations on Remedies of the Evidence of Coverage for further information.

MENTAL HEALTH/SUBSTANCE ABUSE

[Drafting Note: For use when Federal Mental Health Parity Law of 2008 applies:

Treatment(s) for "mental illness" (including "serious emotional disturbances of a child") and substance abuse detoxification are covered on the same basis and are payable in the same amounts as any other illness.

www.aetna.com

A mental illness includes: Anorexia/Bulimia Nervosa, Bipolar disorder, Major depressive disorder, Obsessive compulsive disorder, Panic disorder, Pervasive Mental Developmental Disorder (including Autism), Psychotic Disorders/Delusional Disorder, Schizo-affective Disorder, Schizophrenia and any other mental condition which requires Medically Necessary treatment.

Serious emotional disturbances of a child include one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms and include psychotic features, risk of suicide, and risk of violence due to a mental disorder. These treatments are still subject to: a) prior authorizations and ongoing review to determine coverage; and, b) your plan's copayments and individual and family deductibles, if any.

Behavioral health care benefits are managed by Aetna. Aetna 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 toll-free number on your I.D. card. As with other coverage determinations, you may appeal behavioral health care coverage decisions in accordance with the provisions of your health plan. You may appeal any denials of services based upon medical necessity through independent medical review. See the "Complaints and Appeals/Independent Medical Review" section of this disclosure brochure for additional information about the grievance process and independent medical review.

[Drafting Note: For use when Federal Mental Health Parity Law of 2008 does not apply:

Treatment(s) for "severe mental illness" or "serious emotional disturbances of a child," are not subject to the annual maximums shown on your Schedule of Benefits. Severe mental illness includes, but is not limited to schizophrenia, schizoaffective disorder, bipolar disorder (manic depressive- illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa. Severe emotional disturbances of a child include one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms and include psychotic features, risk of suicide, and risk of violence due to a mental disorder. These treatments are still subject to: a) prior authorizations and ongoing review to determine coverage; and, b) your plan's copayments and individual and family deductibles, if any.

Behavioral health care benefits (e.g., coverage for treatment or care for non-severe mental illness, alcohol abuse and/or substance abuse) are managed by Aetna. Aetna 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. Your coverage will not exceed the maximum number of visits in your Schedule of Benefits or allowed in your Evidence of Coverage.

Aetna may use prior authorizations and ongoing reviews to limit the number of outpatient mental health visits or inpatient days to the minimum it deems to be covered benefits that are medically necessary independent of the maximum number of visits described in your Schedule of Benefits. This means that you may not receive coverage for the maximum number of visits or days specified in your Schedule of Benefits, or the number of visits or days that you and your health professional believe to be appropriate, for a single course of treatment or episode.

For example, psychotherapeutic outpatient treatment for depression may be considered a covered benefit for eight individual visits, but Aetna may, through concurrent review, decide it will not cover any further treatment, even when the Schedule of Benefits states that the maximum number of outpatient visits is up to twenty (20) sessions per year.

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 toll-free number on your I.D. card. As with other coverage determinations, you may appeal behavioral health care coverage decisions in accordance with the provisions of your health plan. You may appeal any denials of services based upon medical necessity through independent medical review. See the "Complaints and Appeals/Independent Medical Review" section of this disclosure brochure for additional information about the grievance process and independent medical review.]

MEDICAL NECESSITY

Use of the term “medically necessary” is referring to health care services and supplies or prescription drugs that a physician or other health care provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating a condition or an illness, injury, disease or its symptoms is:

- In accordance with generally accepted standards of medical or health care practice ;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's condition, illness, injury or disease ;
- Not primarily for the convenience of the patient, physician or other health care provider ;
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's condition, illness, injury, or disease. In determining if a service or supply is medically necessary, Aetna 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, The Milliman Care Guidelines®, InterQual® ISD criteria and Aetna's Coverage Policy Bulletins);
 - Professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;
 - The opinion of health professionals in the generally recognized health specialty involved;
 - The opinion of the attending physicians, which have credence but do not overrule contrary opinions; 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 services and supplies will be covered in accordance with the guidelines determined by Aetna.

FULL PREMIUM COST OF PLAN

Your group is responsible for paying premiums. If you are required to contribute to the premium, your group will tell you the amount and how to pay it. (i.e.: such as payroll deduction).

HOW AETNA COMPENSATES YOUR HEALTH CARE PROVIDER

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

Participating providers in our network are compensated in various ways:

- Per individual service or case (fee for service at contracted rates).
- Per hospital day (per diem contracted rates).
- Capitation (a prepaid amount per member, per month).
- Through Integrated Delivery Systems (IDS), Independent Practice Associations (IPA), Physician Hospital Organizations (PHO), Physician Medical Groups (PMG), behavioral health organizations and similar provider organizations or groups. Aetna pays these organizations, which in turn may reimburse the physician, provider organization or facility directly or indirectly for covered services. In such arrangements, the group or organization has a financial incentive to control the cost of care.

One of the purposes of managed care is to manage the cost of health care. Incentives in compensation arrangements with physicians and health care providers are one method by which Aetna attempts to achieve this goal.

QUALITY ENHANCEMENT

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

- member satisfaction,
- percentage of members who visit the office at least annually,
- medical record reviews,
- the burden of illness of the members that have selected the primary care physician,
- management of chronic illnesses like asthma, diabetes and congestive heart failure;
- whether the physician is accepting new patients; and
- participation in Aetna's electronic claims and referral submission program.

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

CLAIMS PAYMENT FOR NONPARTICIPATING PROVIDERS AND USE OF CLAIMS SOFTWARE

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

TECHNOLOGY REVIEW

Aetna reviews 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. You can find the bulletins at www.aetna.com, under the "Members and Consumers" menu.

YOUR RIGHTS UNDER HIPAA IF YOU LOSE GROUP COVERAGE

Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects health insurance coverage for workers and their families when they change or lose their jobs. California law provides similar and additional protection.

If you lose group health insurance coverage and meet certain criteria, you are entitled to purchase individual health coverage (nongroup) from any health plan that sells individual coverage for hospital, medical or surgical benefits. Every health plan that sells individual health coverage for these benefits must offer individual coverage to an eligible person under HIPAA.

The health plan cannot reject your application if: you are an eligible person under HIPAA; you agree to pay the required premiums; and you live or work inside the plan's service area.

To be considered an eligible person under HIPAA you must meet the following requirements:

- You have 18 or more months of creditable coverage without a break of 63 days or more between any of the periods of creditable coverage or since your most recent coverage was terminated;
- Your most recent creditable coverage was a group, government or church plan that provided hospital, medical or surgical benefits. (COBRA and Cal-COBRA are considered group coverage);

- You were not terminated from your most recent creditable coverage due to nonpayment of premiums or fraud; You are not eligible for coverage under a group health plan, Medicare, or Medicaid (Medi-Cal);
- You have no other health insurance coverage; and
- You have elected and exhausted any continuation coverage you were offered under COBRA or Cal-COBRA.

There are important choices you need to make in a very short time frame regarding the options available to you following termination of your group health care coverage. You should read carefully all available information regarding HIPAA coverage so you can understand fully the special protections of HIPAA coverage and make an informed comparison and choice regarding available coverage. For more information please call **1-800-756-7039**.

If you believe your HIPAA rights have been violated, you should contact the Department of Managed Health Care at **1-888-HMO-2219**, or visit the Department's web site at **www.hmohelp.ca.gov**.

INDIVIDUAL CONTINUATION OF BENEFITS

You may be eligible to convert to individual coverage if you are no longer eligible for your group coverage or if you enroll in COBRA, Cal-COBRA, or USERRA continuation coverage and then lose eligibility for that coverage. See your Evidence of Coverage for details and conditions. You must apply for conversion within 63 days of the date your group coverage ends.

DISENROLLMENT BY MEMBER

If a member elects coverage under an alternative health plan offered by employer group, member's coverage terminates automatically at the time and date the alternate coverage becomes effective.

Members may voluntarily disenroll. Member's coverage terminates at midnight on the last day of the month during which Aetna receives notice of intent to disenroll or for which member requests cancellation.

CLINICAL POLICY BULLETINS

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

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

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

PRECERTIFICATION

Precertification is the process of collecting information prior to inpatient admissions and performance of selected ambulatory procedures and services. The process permits advance eligibility verification, determination of coverage, and communication with the physician and/or you. It also allows Aetna to coordinate your transition from the inpatient setting to the next level of care (discharge planning), or to register you for specialized programs like disease management, case management, or maternity management programs. For additional information on these programs, please contact Member Services. In some instances, precertification is used to inform physicians, members and other health care providers about cost-effective programs and alternative therapies and treatments.

Certain health care services, such as hospitalization or outpatient surgery, require precertification with Aetna. When you are to obtain services requiring precertification from a participating provider, the provider is responsible to precertify those services prior to treatment. If your plan covers self-referred services to network providers, (i.e. Aetna Open Access® HMO, Aetna Choice® POS), or out-of-network benefits and you may self-refer for covered benefits, it is your responsibility to contact Aetna to precertify those services which require precertification to avoid a reduction in benefits paid for that service.

UTILIZATION REVIEW/PATIENT MANAGEMENT

Aetna has developed a patient management program to assist in determining what health care services are covered under the health plan and the extent of such coverage. The program assists you in receiving appropriate health care and maximizing coverage for those health care services. You can avoid receiving an unexpected bill with a simple call to Aetna's Member Services team. 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, Aetna reviews 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.

CONCURRENT REVIEW

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

DISCHARGE PLANNING

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

RETROSPECTIVE RECORD REVIEW

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

SECOND OPINION

When requested by a member or participating provider who is treating a member, Aetna shall authorize a second opinion to be provided by an appropriately qualified health care professional. Reasons for a second opinion to be authorized include, but are not limited to the following:

- The member questions the reasonableness or necessity of recommended surgical procedures.
- The member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.
- If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and the member requests an additional diagnosis.
- If the treatment plan in progress is not improving the medical condition of the member within an appropriate period of time given the diagnosis and plan of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment.

- The member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

If a member or participating provider who is treating the member requests a second opinion, an authorization or denial shall be provided in an expeditious manner. When the member's condition is such that the member faces an imminent and serious treat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or lack of timeliness that would be detrimental to the member's ability to regain maximum function, the second opinion shall be authorized or denied in a timely fashion appropriate for the nature of the member's condition, not to exceed 72 hours after Aetna's receipt of the request, whenever possible.

For additional information regarding second opinions, members may contact Member Services at the toll free telephone number on your ID card.

CONTINUATION OF CARE FOLLOWING TERMINATION OF PROVIDER'S CONTRACT

Aetna shall, at the request of a member, arrange for the continuation of covered services rendered by a terminated participating provider to a member who is undergoing an active course of treatment from a terminated participating provider for an acute condition, serious chronic condition, pregnancy, terminal illness, the care of a child, and previously scheduled surgery or other procedures. For more information regarding continuity of care, contact Member Services at the toll free telephone number on your ID card.

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 as soon as possible.

WHAT TO DO OUTSIDE YOUR AETNA SERVICE AREA

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

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

FOLLOW-UP CARE AFTER EMERGENCIES

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

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.

PRESCRIPTION DRUGS AND DRUG FORMULARY

If the plan purchased by your employer or group includes the pharmacy plan for outpatient prescription drug coverage, your prescription benefit may include a drug formulary. A formulary is a list of prescription drugs and insulin which includes **both** brand name and generic drugs available in your prescription drug benefit plan. The drug formulary list includes a list of prescription drugs that, depending on your prescription drug benefits plan, are covered under your plan. Many drugs, including

many of those listed on the drug formulary list, are subject to rebate arrangements between Aetna and the manufacturer of the drugs. Such rebates are not reflected in and do not reduce the amount a member pays for a prescription drug. This list is distributed to participating providers and is subject to periodic review and modification by Aetna, an affiliate or third party vendor. Throughout the year the Therapeutics Committee may evaluate new drugs once they are approved by the FDA and may re-evaluate the drugs on the current formulary in light of new FDA, manufacturer and peer reviewed information. The Therapeutics Committee reviews the entire formulary at least twice a year. An updated copy of the Drug formulary is available at any time upon request by a member.

Medically necessary outpatient prescription drugs, insulin and pediatric asthma supplies (inhaler spacer, nebulizers*, including face masks and tubing and peak flow meters) are covered. The drug formulary list is subject to change at the discretion of Aetna. In addition, generic and brand non-formulary drugs are covered subject to the Limitations and Exclusions section of the Prescription Drug Rider and the Evidence of Coverage. Coverage of these Non-formulary drugs is subject to change from time to time at the discretion of Aetna. Some items are covered only with prior authorization from Aetna.

Prescriptions must be written by a provider licensed to prescribe federal legend prescription drugs subject to the terms, Aetna policies, and the "Limitations and Exclusions" section described in the Prescription Drug Rider.

Coverage of prescription drugs may be subject to prior authorization. Items covered by a prescription rider are subject to drug utilization review by Aetna and/or the member's participating pharmacy.

Member's participating physician or participating retail or mail order pharmacy may request prior authorization for drugs listed on the Drug Formulary Exclusions List or drugs on requiring Precertification. Such prior authorization requests should be made by the provider to the Precertification Department of Aetna Health's Pharmacy Management Department. The Pharmacy Management Department will respond to complete prior authorization requests within 24 hours of receipt, or in a timely fashion appropriate for the nature of the enrollee's condition. Coverage for prescription drugs requiring precertification shall be based on an individual, case-by-case medical necessity determination and coverage will not apply or extend to other members.

The Formulary Guide contains drugs that have been reviewed by Aetna Health's Therapeutics Committee. The Therapeutics Committee reviews the entire Formulary Guide at least twice a year. The P&T Committee reviews information from a variety of sources, including peer review journals and other independently developed materials. Using this information, the Therapeutics Committee periodically evaluates the therapeutic effectiveness of prescription medications and places them into one of three categories:

- Category I The drug represents an important therapeutic advance.
- Category II The drug is therapeutically similar to other available products.
- Category III The drug has significant disadvantages in safety or efficacy when compared to other similar products.

The drugs in Category I are always included on the Drug Formulary List, and the drugs placed in Category III are not included on the Drug Formulary List. For therapeutically similar drugs in Category II, AETNA selects drugs for the Formulary based on the recommendations of the Therapeutics Committee, the cost effectiveness of the medication, and other factors.

A copy of the Drug Formulary List, or information about the availability of a specific drug may be requested by calling **1-888-792-8742** or the Drug Formulary List may be accessed through our Internet website at **www.aetna.com/formulary/**. Be aware that the presence of a drug on the Drug Formulary List does not guarantee that a member will receive a prescription for that drug from their prescribing provider for a particular medical condition.

A copy of the Aetna Health Formulary, or information about the availability of a specific drug may be requested by calling **1-888-792-8742**, (TDD **1-800-501-9863** for hearing impaired only) or may be accessed through our Internet website at **www.aetna.com**. (Click on "members" and then "prescription plans" to reach the Drug Formulary information.)

Be aware that the presence of a drug on the Drug Formulary does not guarantee that a member will receive a prescription for that drug from their prescribing provider for a particular medical condition.

PEDIATRIC ASTHMA SUPPLIES

The following pediatric asthma supplies are covered for if Medically Necessary upon prescription or upon Participating Physician's order only at Participating Retail or Mail Order Pharmacy. The Member must pay a separate Copayment for each item.

1. Inhaler spacers.
2. Peak flow meters.

* Nebulizers are payable under the Durable Medical Equipment benefit which appears in the medical portion of your plan.

Nebulizers, including face masks and tubing, are payable under the Durable Medical Equipment benefit which appears in the medical portion of your plan.

In an emergency situation, or when the Member is traveling outside of the Aetna HMO Service Area, prescriptions for item 1 above, will be covered even if filled at a Non-Participating Retail Pharmacy; and Nebulizers will be covered even if they are obtained from a Non-Participating Provider.

Members should consult with their treating physician regarding questions about specific medications.

MEMBER SERVICES

To file a complaint 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 e-mail us from your secure member website, Aetna Navigator® at www.aetna.com. Click on "Contact Us" after you log in.

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

Multilingual hotline - 1-888-982-3862

(140 languages are available. You must ask for an interpreter.) TDD 1-800-628-3323 (hearing impaired only)

ILLITERATE AND SPECIAL NEEDS MEMBERS

Aetna recognizes that it may have members who are illiterate and assists these members by providing, upon request, recorded marketing materials. Marketing Representatives conduct on-site employer group benefit management meetings and assist members with special needs in understanding and completing their benefit information. Member Services has a teletype relay toll free number **1-800-628-3321** to assist hearing impaired members

ORGAN DONATION

Every year in the United States, thousands of people die waiting for a life-saving organ transplant. For every 55 people who receive a donated organ, 10 die waiting for organs that never become available. The need for donor organs is critical.

A single donor can help as many as 50 individuals in need of organs or tissues. Medical suitability for donation is determined at the time of death, and the donor's family must give consent. Unfortunately, many families do not consent because they were not aware of their loved one's wishes.

If you would like to become an organ donor, please take the following steps:

1. Indicate your interest to be an organ and tissue donor on your driver's license (ask the motor vehicles department service representative for information when you have your photograph taken for your driver's license).
2. Carry an organ donor card in your wallet. (Call the Coalition on Donation at **1-800-355-SHARE** for a free brochure on donation and donor card.)
3. Most importantly, discuss your decision with family members and loved ones.

Aetna is proud to be a partner of the California Transplant Donor Network (CTDN) in its mission to raise public awareness of organ and tissue donation and link potential organ and tissue donors to individuals awaiting organ and tissue transplantation.

SETTING THE RECORD STRAIGHT - DEBUNKING SOME COMMON MYTHS ABOUT ORGAN DONATION

- The decision to be an organ donor does not affect the quality of medical care you will receive.
- Donation does not disfigure the body or interfere with funeral plans, including open casket services.
- All mainstream organized religions approve of organ donation, and consider it an act of charity, according to the U.S. Department of Health and Human Services.
- Everyone can choose to be an organ or tissue donor. People of all ages, and even people with medical conditions, may be able to donate tissues such as corneas or heart valves.

MEMBER RIGHTS & RESPONSIBILITIES

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

QUALITY MANAGEMENT PROGRAMS

Call Aetna to learn about the specific quality efforts we have under way in your local area. Ask Member Services for the phone number of your regional Quality Management office. If you would like information about Aetna Behavioral Health's Quality Management Program, ask Member Services for the phone number of your Care Management Center Quality Management office.

PRIVACY NOTICE

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

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

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

To obtain a hard copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please write to Aetna's Legal Support Services Department at 151 Farmington Avenue, W121, Hartford, CT 06156. You can also visit our Internet site at www.aetna.com. You can link directly to the Notice of Privacy Practices by Plan Type, by selecting the "Privacy Notices" link at the bottom of the page, and selecting the link that corresponds to your specific plan.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT MEMBER NOTICE

The following information is provided to inform you of certain provisions contained in the Group Health Plan, and related procedures that may be utilized by you 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

If you are a member of an insured plan sponsor or a member of a self-insured plan sponsor who have contracted with us to provide Certificates of Prior Health Coverage, you have the option to request a certificate.

This applies to you if you are a terminated member, or are a member who is currently active but who would like a certificate to verify your status. As a terminated member, you can request a certificate for up to 24 months following the date of your termination. As an active member, you can request a certificate at any time. To request a Certificate of Prior Health Coverage, please contact Member Services at the telephone number on your ID card.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. The company that offers benefits coverage is Aetna Health of California Inc. For self-funded accounts, plan coverage is offered by your employer, with administrative services only provided by Aetna Life Insurance Company.

NOTICE: DISPUTES ARISING FROM OR RELATED TO PLAN MEMBERSHIP WILL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION.

A STATEMENT DESCRIBING AETNA'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

ADDITIONAL INFORMATION ABOUT THE BENEFITS OF THIS PLAN MAY BE OBTAINED BY CALLING **1-800-756-7039**.

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

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

Health benefits plans are offered by Aetna Health of California Inc.

Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Information is believed to be accurate as of the production date; however, it is subject to change.

Aetna is committed to Accreditation by the National Committee for Quality Assurance (NCQA) as a means of demonstrating a commitment to continuous quality improvement and meeting customer expectations. A complete listing of health plans and their NCQA status can be found on the NCQA website located at reportcard.ncqa.org.

To refine your search, we suggest you search these areas: **Managed Behavioral Healthcare Organizations** – for behavioral health accreditation; **Credentials Verification Organizations** – for credentialing certification; **Health Insurance Plans** – for HMO and PPO health plans; **Physician and Physician Practices** – for physicians recognized by NCQA in the areas of heart/stroke care, diabetes care, back pain and medical home. Providers who have been duly recognized by the NCQA Recognition Programs are annotated in the provider listings section of this directory.

Providers, in all settings, achieve recognition by submitting data that demonstrates they are providing quality care. The program constantly assesses key measures that were carefully defined and tested for their relationship to improved care; therefore, NCQA provider recognition is subject to change. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice.

Aetna does not provide care or guarantee access to health services. For up-to-date information, please visit our DocFind® directory at www.aetna.com or, if applicable, visit the NCQA's new top-level recognition listing at recognition.ncqa.org.

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