TAKE CHARGE OF YOUR HEALTH.

CHOOSE AETNA,
CHOOSE AFFORDABLE COVERAGE

The information you need to choose quality and affordable health benefits and insurance coverage.

Aetna®

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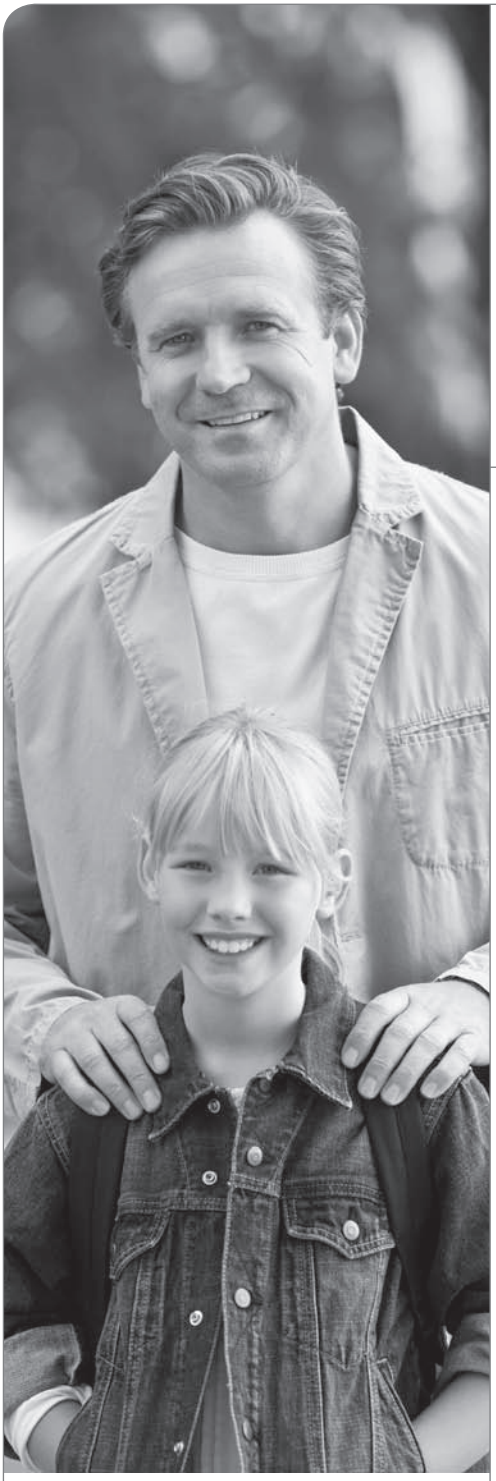

LEARN ABOUT YOUR PLAN CHOICES

AETNA ADVANTAGE PLANS FOR INDIVIDUALS, FAMILIES AND THE SELF-EMPLOYED

Aetna Advantage Plans for Individuals, Families and the Self-Employed are underwritten by Aetna Life Insurance Company (Aetna) through a blanket trust in Delaware. This means that the plan benefits are based on Delaware requirements, and benefits and rates are filed with the Delaware Insurance Department. In some states, individuals may qualify as a business group of one and may be eligible for guaranteed issue, small group health plans. To the extent permitted by law, these plans are medically underwritten and you may be declined coverage in accordance with your health condition.

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HEALTH CARE REFORM — **WHAT YOU NEED TO KNOW**

THE FEDERAL HEALTH CARE REFORM LEGISLATION, KNOWN AS THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, WAS SIGNED INTO LAW ON MARCH 23, 2010 BY PRESIDENT OBAMA.

Since then, Aetna has periodically updated the Aetna Advantage Plans for Individuals, Families and the Self-Employed to include any necessary changes. It is important for you to know that your Aetna Advantage Plan will always comply with all of the federal health care reform legislation.

WOMEN'S PREVENTIVE HEALTH BENEFITS – NEW CHANGES EFFECTIVE AUGUST 1, 2012

As you may know, the legislation includes changes that are being phased in over a number of years. The latest set of changes now includes coverage of Women's Preventive Health Benefits.

As of August 1, 2012, all of the following women's health services are considered preventive and therefore generally covered at no cost share, when provided in-network:

- Well-woman visits (annual routine physical, annual routine GYN exam and prenatal visits)
- Screening for gestational diabetes
- Human Papillomavirus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breastfeeding support, supplies and counseling
- Contraceptive methods and counseling

IF YOU WOULD LIKE TO COMPARE ADDITIONAL PLANS, OR FOR MORE DETAILED PLAN INFORMATION, YOU MAY ALSO VISIT **WWW.HEALTHCARE.GOV.**

THANK YOU

FOR CONSIDERING THE AETNA ADVANTAGE PLANS FOR INDIVIDUALS, FAMILIES AND THE SELF-EMPLOYED. WE ARE PLEASED TO PRESENT THIS INFORMATION KIT, WHICH YOU CAN USE TO FIND A HEALTH INSURANCE PLAN THAT'S RIGHT FOR YOU.

APPLY/ENROLL INSTRUCTIONS

Once you choose a plan, there are two options for you to apply/enroll.

1) If you are working with a broker:

BROKER

You have a partner in the process. Get personalized assistance from your broker, who can answer your questions, help you choose the plan that's right for you and guide you through the application process.

2) If you are applying/enrolling on your own:

ONLINE

You can visit us online at **www.AetnaIndividual.com**. This website offers easy ways to find the plan that is best for you. You can browse our DocFind® online provider directory and apply online.

MAIL

Complete and mail the enclosed application/ enrollment form, in the envelope provided, with one form of payment selected.

PHONE

Any questions? Just call 1-800-MY-HEALTH (1-800-694-3258) and we'll be happy to answer your questions as well as help you complete the application.

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TOP REASONS TO **CHOOSE AETNA**

In 2010, for the third year in a row, Aetna was named the most admired health care insurance company by *Fortune* magazine.*

ROBUST COVERAGE, COMPETITIVE COSTS

We offer plans with valuable features, which may include:

- An excellent combination of quality coverage and competitively priced premiums
- The freedom to see doctors whenever you need to – without referrals
- Coverage for preventive care, prescription drugs, doctor visits, hospitalization and immunizations
- No copayments for well-women exams when you visit a network provider
- No claim forms to fill out when you use a network provider
- National provider networks offer you a vast selection of participating physicians and hospitals

COVERAGE WHEN YOU TRAVEL

Like to travel? You have access to covered services from a national network of doctors and hospitals that accept our negotiated fees.

FAMILY COVERAGE

Apply for coverage for yourself, for you and your spouse, or for your whole family.

TAX ADVANTAGES

We also offer high-deductible plans that are compatible with tax-advantaged health savings accounts (HSAs). You can contribute money to your HSA tax free. That money earns interest tax free. And qualified withdrawals for medical expenses are tax free, too.

ONLINE HEALTH TOOLS AND RESOURCES

Need health information fast? We offer secure Internet access to reliable health information tools and resources through our secure member website. Also, here are three examples of our online tools that will help make it easier for you to make informed decisions about your health care:

- **Member Payment Estimator**
  Our group of Web-based decision-support tools is designed to help you plan for your health care expenses by giving you health care costs and other information you need to make better decisions. For tools that provide both in- and out-of-network cost information, you can see the potential cost savings when a participating in-network provider (physician, dentist and facility) is used.
- **Aetna SmartSource℠**
  Aetna SmartSource will change the way you research conditions, symptoms and more. Unlike most search engines and general health websites, Aetna SmartSource delivers information that is specific to you based on where you live, your selected Aetna insurance plan and other information.
- **Mobile Web**
  Mobile access to the most popular and useful features of Aetna.com is simplified for on-the-go use. Our health-related mobile applications can help you save money and easily access health information.

LET'S TALK

HAVE QUESTIONS?

Call
your broker

or

Email
AetnaAdvantagePlans@aetna.com

WANT A QUOTE NOW?

Visit
www.AetnaIndividual.com

or

Call
1-800-MY-HEALTH
(1-800-694-3258)

* *Fortune* magazine, March 22, 2010, March 16, 2009, and March 17, 2008

MORE REASONS TO CHOOSE AN AETNA ADVANTAGE PLAN

AFFORDABLE QUALITY AND CHOICES

Our plans are designed to offer you quality coverage at an excellent value. You can choose from a wide range of health insurance plans that offer varying amounts of coverage depending on you or your family's specific needs.

Generally speaking, the lower your "premiums," or monthly payments, the higher your "deductible," which is the amount you pay out of pocket before the plan begins paying for covered expenses.

You'll pay less by using "in-network" doctors, hospitals, pharmacies and other health care providers who participate in the Aetna network than by using "out-of-network" providers.

This allows you to be in control of how much you spend by matching the type of coverage you desire with the premium that matches your budget.

ABOUT HEALTH SAVINGS ACCOUNTS (HSAs)

Many of our high-deductible plans are health savings account (HSA) compatible. That means you pay lower premiums and get tax-advantaged savings. An HSA is a personal account that lets you pay for qualified medical expenses with tax-advantaged funds. You or an eligible family member make contributions to your HSA tax free, and those dollars earn interest tax free. Then, when you make withdrawals from your account to pay for qualified health care expenses, they're tax free, too.

OUR PLANS ARE DESIGNED TO OFFER YOU QUALITY COVERAGE AT AN EXCELLENT VALUE

FAMILY COVERAGE

Apply for coverage for yourself, for you and your spouse, or for your whole family.

IT'S EASY TO ESTABLISH AN HSA

Once you are enrolled in a qualifying High Deductible Health Plan, Aetna will send you a letter outlining how to enroll in an HSA with Bank of America.

There is no additional charge to you for opening up this account.

WHY CHOOSE AN AETNA HEALTHFUND HSA?

- No set-up fees
- No monthly administration fee
- No withdrawal forms required
- Convenient access to HSA funds via debit card or online payments
- Track HSA activity online

You can track your HSA activity through Bank of America, too. Bank of America is the HSA administrator. Just log in to **www.bankofamerica.com/benefitslogin**.

ADD DENTAL PPO

With the Aetna Advantage Dental PPO insurance plan, participating dentists provide covered services at negotiated rates and may also provide discounts on non-covered services such as cosmetic tooth whitening and orthodontic care, so you generally pay less out of pocket. You also have the flexibility to visit a dentist who does not participate in the Aetna network, though you will not have access to negotiated fees.

Note: Dental coverage is available only if you purchase medical coverage. Discounts for non-covered services may not be available in all states.

WHAT DOES THAT MEAN?

Here are a few definitions of terms you'll see throughout this brochure. For a more in-depth list of terms, please visit **www.planforyourhealth.com.***

Coinsurance – The dollar amount that the plan and you pay for covered benefits after the deductible is paid.

Copayment (Copay) – A fixed dollar amount that you must contribute toward the cost of covered medical services under a health plan. For HSA compatible plans, copayment will apply to your out-of-pocket max.

Deductible – A fixed yearly dollar amount you pay before the benefits of the plan policy start.

Exclusions and Limitations — Specific conditions or circumstances that are not covered under a plan.

Out-of-Pocket Maximum – The amounts such as coinsurance and deductibles that you are required to contribute toward the cost of health services covered by the benefits plan before the plan pays 100% of additional out-of-pocket costs.

Premium – The amount charged for a health insurance policy or health benefits plan on a monthly basis.

Pre-existing Condition – A health condition or medical problem that was diagnosed or treated (including the use of prescription drugs) before getting coverage under a new insurance health plan.

* Plan For Your Health is a public education program from Aetna and the Financial Planning Association.

VALUE-ADDED PROGRAMS

AETNA ADVANTAGE PLANS INCLUDE SPECIAL PROGRAMS[1] TO COMPLEMENT OUR HEALTH COVERAGE

These programs include health information programs and tools, and offer you access to substantial savings on products to help you stay healthy. These programs are offered in addition to your Aetna Advantage Plan and are NOT insurance.

Following is a description of some of the discount programs included with our plans. For more information on any of these programs, please visit us online at **www.aetna.com.**

DISCOUNT PROGRAMS

Aetna Fitness℠ Discount Program

Offers preferred rates on gym memberships. It also offers discounts on at-home weight loss programs, home fitness options, and one-on-one health coaching services through GlobalFit™.

Aetna Hearing℠ Discount Program

Provides access to discounts on hearing devices and hearing exams from HearPO®. Average savings on hearing aids is 25 percent.

Aetna Natural Products and Services℠ Discount Program

Offers reduced rates on acupuncture, chiropractic care, massage therapy and dietetic counseling through American Specialty Health Incorporated (ASH) and its subsidiaries. ASH also offers discounts on over-the-counter vitamins, herbal and nutritional supplements, and natural products. Through Vital Health Network, members can receive a discount on online consultations and alternative remedies provided by medical doctors for a variety of conditions.

Aetna Vision℠ Discount Program

Offers discounts on vision exams, lenses and frames. A member must use a provider in the EyeMed Select Network. LASIK surgery discounts are also available.

Aetna Weight Management℠ Discount Program

Offers savings on eDiets® online diet plans, Jenny Craig® weight loss programs and products and Nutrisystem weight loss meal plans. Members can meet their specific weight loss goals and save money with a variety of programs and plans to choose from.

HEALTH MANAGEMENT **TOOLS**

INFORMED HEALTH® LINE

Our 24-hour toll-free number that puts you in touch with experienced registered nurses and an audio library for information on thousands of health topics.

THE AETNA SECURE MEMBER WEBSITE

Register and log on to our secure member website to check claims status, contact Aetna Member Services, estimate the costs of health care services, and more. The secure member website provides a starting point to find answers about health care, types of treatment, cost of services and more to help members make more informed decisions. Plus, members have access to their own Personal Health Record*, a single, secure place where they can view their medical history and add other health information.

While only your doctor can diagnose, prescribe or give medical advice, the Informed Health Line nurses can provide information on more than 5,000 health topics. Contact your doctor first with any questions or concerns regarding your health care needs.

Discount programs provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Aetna may receive a percentage of the fee you pay to the discount vendor.

1 Availability varies by plan. Talk with your Aetna representative for details.

* The Aetna Personal Health Record should not be used as the sole source of information about your health conditions or medical treatment.

HOW CAN I SAVE MONEY ON MY HEALTH CARE BENEFITS EXPENSES?

It's a sign of the times — people are looking to trim household expenses wherever they can. Aetna is here to help. We've prepared special tips to help you save money on health care benefits — without compromising your health.

Healthy Savings from Aetna gives you eight ways to start saving now with your Aetna health insurance plan. Take advantage of easy-to-follow tips, tools and charts that show you how you may save. Check out all the ways you can save at **www.aetna.com/healthysavings.**

AETNA NETWORK PROVIDERS **SAVE YOU MONEY**

KEEP ACCESS TO QUALITY CARE AFFORDABLE WITH THE AETNA PROVIDER NETWORK

IS YOUR DOCTOR IN THE AETNA NETWORK?

Our provider network is quite extensive throughout the country, including your state. In fact, your doctor may already be part of the Aetna Advantage Plan network. To check which local physicians, hospitals, pharmacies and eyewear providers participate in your area, please visit **www.AetnaIndividual.com** and select "Find a Doctor", or call 1-800-694-3258 and ask for a directory of providers.

By using providers in the Aetna network, you can take advantage of the significant discounts we have negotiated to help lower your out-of-pocket costs for medically necessary care. This can help you get the care you need at an affordable price.

Let's look at some examples, so you can see your network savings in action.

These examples are based on the following Aetna plan features and assume you've already met your deductible (the fixed amount that you must pay for covered medical services before your plan will pay benefits):

What your plan pays (plan coinsurance):

80% in network / 60% out of network

What you pay (coinsurance):

20% in network / 40% out of network

IMPORTANT ADDITIONAL INFORMATION

The "recognized amount":

When you receive services from a provider who is not in the Aetna network, the plan pays based on the "recognized" amount/charge, which is described in your benefit plan. In these examples, if you use a health care provider who is not in the Aetna network, you may be responsible for the entire difference between what the provider bills and the recognized amount/charge. As the examples show, that difference can be large.

EXAMPLE 1

You have been getting care for an ongoing condition from a specialist who is not in the Aetna network. You are thinking about switching to a specialist in the Aetna network. This example illustrates what you may save if you switch.

OFFICE VISIT		In-Network	Out-of-Network+
Doctor bill	Amount billed	$150	$150
Amount Aetna uses to calculate payment	Aetna's rate* in-network	$90*	
	Recognized amount** out-of-network		$90**
What your plan will pay	Aetna's negotiated rate/ recognized amount	$90	$90
	Percent your plan pays	80%	60%
	Amount of Aetna's negotiated rate/recognized amount covered under plan	$72*	$54**
What you owe	Your coinsurance responsibility	$18	$36
	Amount that can be balance billed to you	$0	$60
YOUR TOTAL RESPONSIBILITY		**$18*** **	**$96*** **

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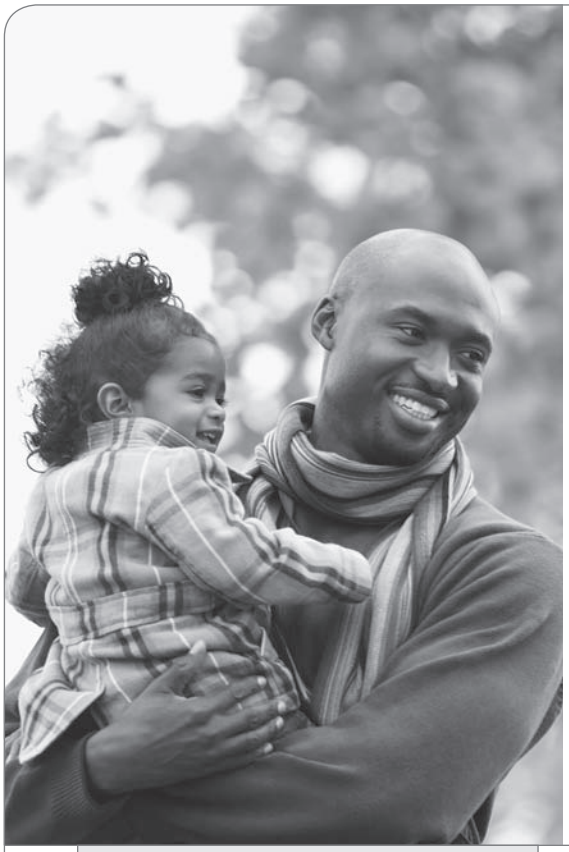


EXAMPLE 2

You need outpatient surgery for a simple procedure and are deciding if you will have it done by a physician in the Aetna network. This example gives you an idea of how much you might owe depending on your choice.

OUTPATIENT SURGERY		In-Network	Out-of-Network+
Surgery bill†	Amount billed	$2,000	$2,000
Amount Aetna uses to calculate payment	Aetna's rate* in-network	$600*	
	Recognized amount** out-of-network		$600**
What your plan will pay	Aetna's negotiated rate/recognized amount	$600	$600
	Percent your plan pays	80%	60%
	Amount of Aetna's negotiated rate/recognized amount covered under plan	$480*	$360**
What you owe	Your coinsurance responsibility	$120	$240
	Amount that can be balance billed to you	$0	$1,400*
YOUR TOTAL RESPONSIBILITY		**$120*** **	**$1,640*** **

EXAMPLE 3

You need to go to the hospital but it is not an emergency. It turns out that you have to stay in the hospital for five days. This example gives you an idea of how much you might owe to the hospital depending on whether it is in the Aetna network.

FIVE-DAY HOSPITAL STAY		In-Network	Out-of-Network+
Hospital bill	Amount billed	$25,000	$25,000
Amount Aetna uses to calculate payment	Aetna's rate* in-network	$8,750*	
	Recognized amount** out-of-network		$8,750**
What your plan will pay	Aetna's negotiated rate/ recognized amount	$8,750	$8,750
	Percent your plan pays	80%	60%
	Amount of Aetna's negotiated rate/recognized amount covered under plan	$7,000*	$5,250**
What you owe	Your coinsurance responsibility	$1,750	$3,500
	Amount that can be balance billed to you	$0	$16,250*
YOUR TOTAL RESPONSIBILITY		**$1,750*** **	**$19,750*** **

BY USING PROVIDERS IN THE AETNA NETWORK, YOU CAN TAKE ADVANTAGE OF THE SIGNIFICANT DISCOUNTS WE HAVE NEGOTIATED TO HELP LOWER YOUR OUT-OF-POCKET COSTS FOR MEDICALLY NECESSARY CARE.

† You also may be responsible for a portion of fees charged by the facility in which the surgery takes place. The figures in the example do not include those facility fees.
* Doctors, hospitals and other health care providers in the Aetna network accept our payment rate and agree that you owe only your deductible and coinsurance.
** When you go out of network, the plan determines a recognized amount. You may be responsible for the difference between the billed amount and the recognized amount. See your plan documents for details. Your plan may instead call the recognized amount the recognized charge.
*** Most plans cap out-of-pocket costs for covered services. The deductible and coinsurance you owe count toward that cap. But when you go outside the network, the difference between the health care provider's bill and the recognized amount does not count toward that cap.

SAVE EVEN MORE

MORE WAYS TO CONTROL HEALTH CARE COSTS

ENJOY THE VALUE OF GENERIC PRESCRIPTION DRUGS

Generic prescription drugs can save you money. They go through rigorous testing as required by the Food and Drug Administration. So you can be sure they are as safe and effective as their brand-name counterparts.

If a generic prescription drug is right for you, we offer many ways to help you access them:

- Tools to compare the costs of brand-name and generic drugs
- Outreach efforts that show how you can save with generic drugs
- Prescriptions filled with a generic, when appropriate
- Plan options that may include special terms about use of generics

AETNA RX HOME DELIVERY®

With this mail-order prescription drug program, order generic and brand prescription medications through our convenient and easy-to-use mail order pharmacy. To learn more or to download order forms, visit **www.AetnaRxHomeDelivery.com.**

SAVE ON LAB WORK

With your Aetna medical plan, you can save on testing and other lab services when you use Quest Diagnostics.

Here's how it works:

- If your doctor is collecting your sample in the office, ask him or her to send your testing to Quest.
- If your doctor is sending you outside the office to collect your sample, ask for a lab requisition form to Quest, and visit your nearest Quest office.

LOOK HOW MUCH YOU CAN SAVE!

	In-network lab	In-network hospital lab	Out-of-network lab
Cost of lab test	$30.00	$60.00	$300.00
Patient's copay	x20%	x20%	x40%
Patient pays	$6.00	$12.00	$120.00

BE A BETTER HEALTH CARE CONSUMER. ASK YOUR DOCTOR TO ONLY USE IN-NETWORK LABS, AND PAY LESS.

YOU'RE MOBILE. **SO ARE WE.**

Aetna Mobile puts our most popular online features at your fingertips. No matter where you are, you still want easy access to your health information to make the best decisions you can.

Want to look up a claim while you're waiting in line? Find a doctor and make an appointment while you're out shopping? Research the price of your medication during your train ride to work?

When you go to Aetna.com from your mobile phone's web browser, you can:

- Find a doctor, dentist or facility
- Buy health insurance
- Register for your secure member site
- Access your personal health record (PHR)
- View your member ID card
- Contact us by phone or email

Explore a smarter health plan.
Visit us at **www.aetna.com**.

RATING AREAS*

ARIZONA

YOUR RATES WILL DEPEND ON THE AREA IN WHICH YOUR COUNTY IS LOCATED. FOR MORE INFORMATION OR A QUOTE ON WHAT YOUR RATE WOULD BE, **CALL YOUR BROKER OR 1-800-MY-HEALTH.**

AREA 1

Maricopa

AREA 2

Pinal (all zips except 85240, 85243)

AREA 3

Yavapai (all zips except 85324)

AREA 4

Yuma

AREA 5

Pima

AREA 6

Santa Cruz

AREA 7

Cochise

AREA 8

Coconino

AREA 9

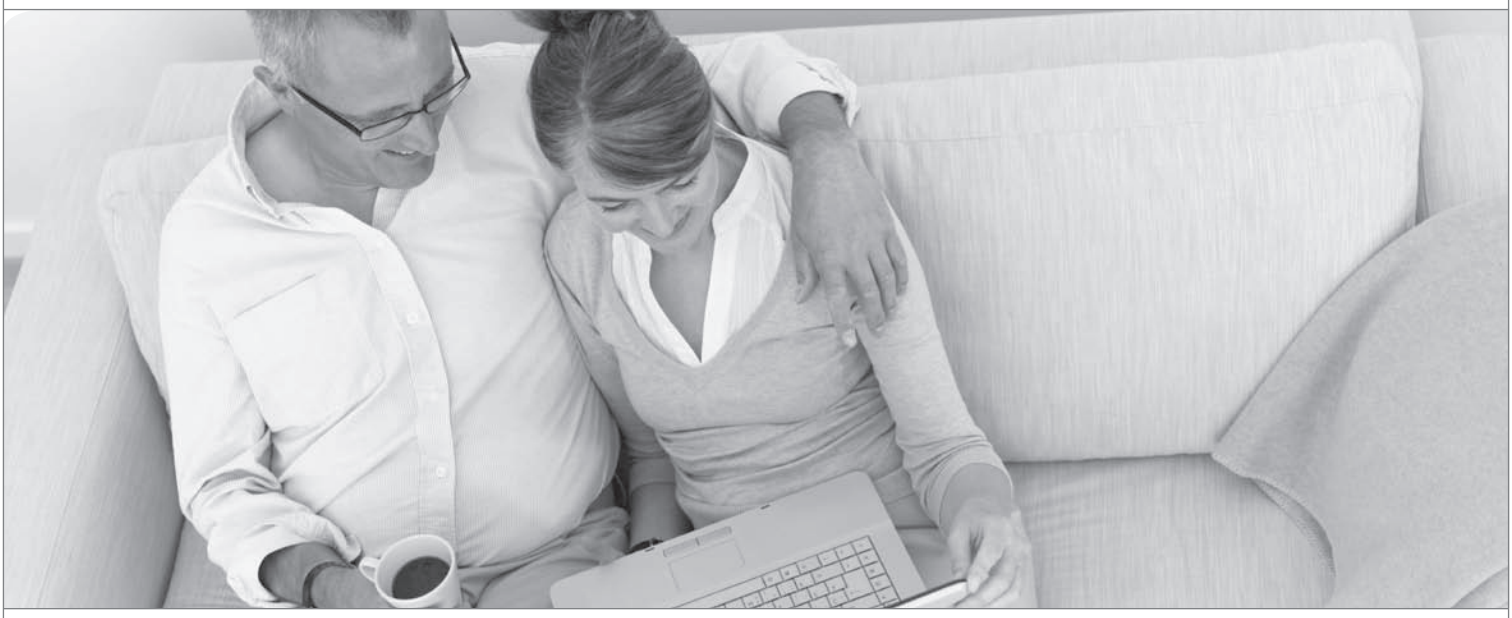
Mohave (86401, 86402, 86409)

AREA 10

Apache
Gila
Graham
Greenlee
La Paz
Mohave (all except 86401, 86402, 86409)
Navajo

AREA 11

Pinal (85240, 85243)
Yavapai (85324)



* Networks may not be available in all ZIP codes and are subject to change.

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HOW DO I MAKE **SMART HEALTH CARE DECISIONS?**

Sure, health care options can sometimes be confusing. But it's important to understand your health and personal finance choices, so you can plan ahead and make wise decisions. **PlanforYourHealth.com** can help you choose the best health care alternatives for you and your family.

This website offers useful tips on different insurance products, plus interactive tools that show how big life changes will affect your health care options.

Visit **www.planforyourhealth.com**, and get guidance for different stages in your life — and in your health.

YOUR PREFERRED PROVIDER ORGANIZATION (PPO) **PLAN OPTION(S)**

ROBUST COVERAGE AND THE FLEXIBILITY OF LOWER MONTHLY PAYMENTS BALANCED WITH A DEDUCTIBLE... WHERE YOU DON'T PAY A LOT FOR FREQUENT DOCTOR VISITS

FEATURING:

- Robust coverage with a choice of varying deductible levels

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PPO 2500

ARIZONA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	 $2,500 $5,000	 $5,000 $10,000
Coinsurance (Member's responsibility)	20% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	 $5,000 $10,000	 $7,500 $15,000
Out-of-Pocket Maximum Individual Family	 $7,500 $15,000	 $12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit *Unlimited visits* General Physician, Family Practitioner, Pediatrician or Internist	$30 copay deductible waived	50% after deductible
Specialist Visit *Unlimited visits*	$50 copay deductible waived	50% after deductible
Hospital Admission	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible
Urgent Care Facility	$50 copay deductible waived	50% after deductible
Emergency Room	20% after $150 copay** (waived if admitted) ; deductible applies	
Annual Routine Gyn Exam *No waiting period* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	20% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	20% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	20% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	20% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	20% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	$500	$500
	Does not apply to generic	
Generic	$15 copay deductible waived	$15 copay plus 50% deductible waived
Preferred Brand	$40 copay after deductible	$40 copay plus 50% after deductible
Non-Preferred Brand	$65 copay after deductible	$65 copay plus 50% after deductible
Self-Injectables	30% after deductible	Not covered

* Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

\+ For important information on your costs and how Aetna pays for out-of-network care, read "What you need to know about your out-of-network costs."

This material is for information only. A summary of exclusions is listed in the Aetna Advantage Plan brochure. For a full list of benefit coverage and exclusions refer to the plan documents. Plans may be subject to medical underwriting or other restrictions. Rates and benefits vary by location. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Health insurance plans contain exclusions and limitations. Information is believed to be accurate as of the production date; however, it is subject to change.

Aetna Advantage Plans for Individuals, Families and the Self-Employed are underwritten by Aetna Life Insurance Company (Aetna) through a blanket trust in Delaware. This means that the plan benefits are based on Delaware requirements, and benefits and rates are filed with the Delaware Insurance Department. In some states, individuals may qualify as a business group of one and may be eligible for guaranteed issue, small group health plans. To the extent permitted by law, these plans are medically underwritten and you may be declined coverage in accordance with your health condition.

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Aetna®

PPO 3500

ARIZONA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	 $3,500 $7,000	 $7,000 $14,000
Coinsurance (Member's responsibility)	20% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	 $4,000 $8,000	 $5,500 $11,000
Out-of-Pocket Maximum Individual Family	 $7,500 $15,000	 $12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit *Unlimited visits* General Physician, Family Practitioner, Pediatrician or Internist	$30 copay deductible waived	50% after deductible
Specialist Visit *Unlimited visits*	$50 copay deductible waived	50% after deductible
Hospital Admission	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible
Urgent Care Facility	$50 copay deductible waived	50% after deductible
Emergency Room	20% after $150 copay** (waived if admitted) ; deductible applies	
Annual Routine Gyn Exam *No waiting period* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	20% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	20% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	20% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	20% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	20% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	$500	$500
	Does not apply to generic	
Generic	$15 copay deductible waived	$15 copay plus 50% deductible waived
Preferred Brand	$40 copay after deductible	$40 copay plus 50% after deductible
Non-Preferred Brand	$65 copay after deductible	$65 copay plus 50% after deductible
Self-Injectables	30% after deductible	Not covered

* Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

\+ For important information on your costs and how Aetna pays for out-of-network care, read "What you need to know about your out-of-network costs."

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63.06.300.1-AZ C (10/12)

Aetna®

PPO 5000

ARIZONA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	 $5,000 $10,000	 $10,000 $20,000
Coinsurance (Member's responsibility)	20% after deductible up to out-of pocket max	50% after deductible up to out-of pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	 $5,000 $10,000	 $2,500 $5,000
Out-of-Pocket Maximum Individual Family	 $10,000 $20,000	 $12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit *Unlimited visits* General Physician, Family Practitioner, Pediatrician or Internist	$30 copay deductible waived	50% after deductible
Specialist Visit *Unlimited visits*	$50 copay deductible waived	50% after deductible
Hospital Admission	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible
Urgent Care Facility	$50 copay deductible waived	50% after deductible
Emergency Room	20% after $150 copay** (waived if admitted) ; deductible applies	
Annual Routine Gyn Exam *No waiting period* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	20% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	20% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	20% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	20% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	20% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	$500	$500
	Does not apply to generic	
Generic	$15 copay deductible waived	$15 copay plus 50% deductible waived
Preferred Brand	$40 copay after deductible	$40 copay plus 50% after deductible
Non-Preferred Brand	$65 copay after deductible	$65 copay plus 50% after deductible
Self-Injectables	30% after deductible	Not covered

* Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

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63.06.300.1-AZ C (10/12)

Aetna®

YOUR HIGH DEDUCTIBLE **PLAN OPTION(S)**

LOWER PREMIUM COSTS ... AND A HEALTH SAVINGS ACCOUNT (HSA) COMPATIBLE PLAN THAT OFFERS TAX-ADVANTAGED SAVINGS

FEATURING:

- 0% coinsurance in network after your deductible is met

PPO HIGH DEDUCTIBLE 3500
(HSA COMPATIBLE)
ARIZONA
AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	 $3,500 $7,000	 $6,000 $12,000
Coinsurance (Member's responsibility)	0% after deductible up to out-of pocket max.	50% after deductible up to out-of pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	 $0 $0	 $6,500 $13,000
Out-of-Pocket Maximum Individual Family	 $3,500 $7,000	 $12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit *Unlimited visits* General Physician, Family Practitioner, Pediatrician or Internist	0% after deductible	50% after deductible
Specialist Visit *Unlimited visits*	0% after deductible	50% after deductible
Hospital Admission	0% after deductible	50% after deductible
Outpatient Surgery	0% after deductible	50% after deductible
Urgent Care Facility	0% after deductible	50% after deductible
Emergency Room	0% after deductible	
Annual Routine Gyn Exam *No waiting period* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	0% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	0% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	0% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	0% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	0% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	Integrated Medical/Rx Deductible	
Generic	0% after Medical/ Rx deductible	50% after Medical/ Rx deductible
Preferred Brand	0% after Medical/ Rx deductible	50% after Medical/ Rx deductible
Non-Preferred Brand	0% after Medical/ Rx deductible	50% after Medical/ Rx deductible
Self-Injectables	0% after Medical/ Rx deductible	Not covered

* Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

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63.06.300.1-AZ C (10/12)

Aetna®

PPO HIGH DEDUCTIBLE 5500
(HSA COMPATIBLE)
ARIZONA
AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	 $5,500 $11,000	 $10,000 $20,000
Coinsurance (Member's responsibility)	0% after deductible up to out-of pocket max.	50% after deductible up to out-of pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	 $0 $0	 $2,500 $5,000
Out-of-Pocket Maximum Individual Family	 $5,500 $11,000	 $12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit *Unlimited visits* General Physician, Family Practitioner, Pediatrician or Internist	0% after deductible	50% after deductible
Specialist Visit *Unlimited visits*	0% after deductible	50% after deductible
Hospital Admission	0% after deductible	50% after deductible
Outpatient Surgery	0% after deductible	50% after deductible
Urgent Care Facility	0% after deductible	50% after deductible
Emergency Room	0% after deductible	
Annual Routine Gyn Exam *No waiting period* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	0% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	0% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	0% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	0% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	0% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	Integrated Medical/Rx Deductible	
Generic	0% after Medical/ Rx deductible	50% after Medical/ Rx deductible
Preferred Brand	0% after Medical/ Rx deductible	50% after Medical/ Rx deductible
Non-Preferred Brand	0% after Medical/ Rx deductible	50% after Medical/ Rx deductible
Self-Injectables	0% after Medical/ Rx deductible	Not covered

* Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

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63.06.300.1-AZ C (10/12)

Aetna®

YOUR VALUE **PLAN OPTION(S)**

AFFORDABILITY — A BALANCE OF LOWER MONTHLY PREMIUMS AND GREATER COST SHARING WITH QUALITY COVERAGE

FEATURING:

- Coverage for routine and major services with lower monthly premiums (that's the "Value" part)

PPO VALUE 1500

ARIZONA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	 $1,500 $3,000	 $3,000 $6,000
Coinsurance (Member's responsibility)	30% after deductible up to out-of pocket max.	50% after deductible up to out-of pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	 $3,500 $7,000	 $7,000 $14,000
Out-of-Pocket Maximum Individual Family	 $5,000 $10,000	 $10,000 $20,000
	Includes deductible	
Non-Specialist Office Visit General Physician, Family Practitioner, Pediatrician or Internist	Visits 1-5 $40 copay; deductible waived. Thereafter, visits 6+, 30% coinsurance after deductible. Shared visits with specialist and non-specialist	50% after deductible
Specialist Visit	Visits 1-5 $50 copay; deductible waived. Thereafter, visits 6+, 30% coinsurance after deductible. Shared visits with specialist and non-specialist	50% after deductible
Hospital Admission	30% after deductible	50% after deductible
Outpatient Surgery	30% after deductible	50% after deductible
Urgent Care Facility	$75 copay deductible waived	50% after deductible
Emergency Room	$350 copay** (waived if admitted)	
Annual Routine Gyn Exam *No waiting period* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	30% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	30% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	30% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	30% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	30% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	Not Applicable	Not Applicable
Generic	$15 copay	$15 copay plus 50%
Preferred Brand	Not covered	Not covered
Non-Preferred Brand	Not covered	Not covered
Self-Injectables	Not covered	Not covered

* Maximum applies to combined in and out-of-network benefits.

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Aetna®

PPO VALUE 5000

ARIZONA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	 $5,000 $10,000	 $10,000 $20,000
Coinsurance (Member's responsibility)	30% after deductible up to out-of pocket max.	50% after deductible up to out-of pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	 $3,000 $6,000	 $2,500 $5,000
Out-of-Pocket Maximum Individual Family	 $8,000 $16,000	 $12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit General Physician, Family Practitioner, Pediatrician or Internist	Visits 1-5 $40 copay; deductible waived. Thereafter, visits 6+, 30% coinsurance after deductible. Shared visits with specialist and non-specialist	50% after deductible
Specialist Visit	Visits 1-5 $50 copay; deductible waived. Thereafter, visits 6+, 30% coinsurance after deductible. Shared visits with specialist and non-specialist	50% after deductible
Hospital Admission	30% after deductible	50% after deductible
Outpatient Surgery	30% after deductible	50% after deductible
Urgent Care Facility	$75 copay deductible waived	50% after deductible
Emergency Room	$350 copay** (waived if admitted)	
Annual Routine Gyn Exam *No waiting period* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	30% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	30% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	30% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	30% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	30% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	Not Applicable	Not Applicable
Generic	$15 copay	$15 copay plus 50%
Preferred Brand	Not covered	Not covered
Non-Preferred Brand	Not covered	Not covered
Self-Injectables	Not covered	Not covered

* Maximum applies to combined in and out-of-network benefits.

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63.06.300.1-AZ C (10/12)

PPO VALUE 10000

ARIZONA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	$10,000 $20,000	$10,000 $20,000
Coinsurance (Member's responsibility)	30% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	$2,500 $5,000	$2,500 $5,000
Out-of-Pocket Maximum Individual Family	$12,500 $25,000	$12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit General Physician, Family Practitioner, Pediatrician or Internist	Visits 1-5 $40 copay; deductible waived. Thereafter, visits 6+, 30% coinsurance after deductible. Shared visits with specialist and non-specialist	50% after deductible
Specialist Visit	Visits 1-5 $50 copay; deductible waived. Thereafter, visits 6+, 30% coinsurance after deductible. Shared visits with specialist and non-specialist	50% after deductible
Hospital Admission	30% after deductible	50% after deductible
Outpatient Surgery	30% after deductible	50% after deductible
Urgent Care Facility	$75 copay deductible waived	50% after deductible
Emergency Room	$350 copay** (waived if admitted)	
Annual Routine Gyn Exam *No waiting period* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	30% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	30% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	30% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	30% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	30% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	Not Applicable	Not Applicable
Generic	$15 copay	$15 copay plus 50%
Preferred Brand	Not covered	Not covered
Non-Preferred Brand	Not covered	Not covered
Self-Injectables	Not covered	Not covered

* Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

\+ For important information on your costs and how Aetna pays for out-of-network care, read "What you need to know about your out-of-network costs."

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Aetna®

YOUR AETNA OPEN ACCESS® MANAGED CHOICE® SAVINGS PLUS **PLAN OPTION(S)**

SAVINGS — THE SAME TYPES OF COVERAGE AS OTHER AETNA MEDICAL PLANS, BUT AT A LOWER PREMIUM COST

FEATURING:

- Highest benefit level and the lowest out-of-pocket costs when you access care through the Savings Plus network

AETNA OPEN ACCESS® MANAGED CHOICE® SAVINGS PLUS 3000

ARIZONA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	Maximum Savings	Out-of-Network+
Deductible Individual Family	$3,000 $6,000	$6,000 $12,000 (Non-designated and Out-of-Network providers)++
Coinsurance (Member's responsibility)	20% / 40% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max. (Non-designated and Out-of-Network providers)++
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	$7,000 $14,000	$6,500 $13,000 (Non-designated and Out-of-Network providers)++
Out-of-Pocket Maximum Individual Family	$10,000 $20,000	$12,500 $25,000 (Non-designated and Out-of-Network providers)++
	Includes deductible	
Non-Specialist Office Visit General Physician, Family Practitioner, Pediatrician or Internist	Visits 1-3: $50 copay, deductible waived; Visits 4+ member pays 100%. Aetna Pays 100% once out-of-pocket maximum is reached	50% after deductible
Specialist Visit	20% after deductible	50% after deductible (Non-designated and Out-of-Network providers)++
Hospital Admission	40% after deductible	50% after deductible (Non-designated and Out-of-Network providers)++
Outpatient Surgery	40% after deductible	50% after deductible (Non-designated and Out-of-Network providers)++
Urgent Care Facility	$100 copay deductible waived	50% after deductible
Emergency Room	$500 copay** (waived if admitted)	
Annual Routine Gyn Exam *No waiting period* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	20% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	40% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	20% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	20% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	40% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	Not Applicable	Not Applicable
Generic	$20 copay	$20 copay plus 50%
Preferred Brand	Not covered	Not covered
Non-Preferred Brand	Not covered	Not covered
Self-Injectables	Not covered	Not covered

* Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

\+ For important information on your costs and how Aetna pays for out-of-network care, read "What you need to know about your out-of-network costs."

++ For important information on what you will pay for Non-Designated and Out-of-Network Providers, read "How do the Savings Plus plans work"?

This plan provides preferred benefit coverage and access to covered services and supplies through a designated network of health care providers and facilities that are unique to your plan.

This Plan includes different benefit levels based upon the type of network provider that you use (designated or non-designated) or if you choose to see a non-preferred care provider. It is designed to lower your out-of-pocket costs when you use these designated network providers for covered expenses. These designated network providers are identified in the printed directory and the on-line version of the directory. Aetna also contracts with other network providers that are available to you under the plan (referred to as non-designated network providers), but your cost sharing will be at a much higher level when you use these providers.

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63.06.300.1-AZ C (10/12)

AETNA OPEN ACCESS® MANAGED CHOICE® SAVINGS PLUS 6500

ARIZONA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	Maximum Savings	Out-of-Network+
Deductible Individual Family	$6,500 $13,000	$10,000 $20,000 (Non-designated and Out-of-Network providers)++
Coinsurance (Member's responsibility)	20% / 40% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max. (Non-designated and Out-of-Network providers)++
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	$6,000 $12,000	$2,500 $5,000 (Non-designated and Out-of-Network providers)++
Out-of-Pocket Maximum Individual Family	$12,500 $25,000	$12,500 $25,000 (Non-designated and Out-of-Network providers)++
	Includes deductible	
Non-Specialist Office Visit General Physician, Family Practitioner, Pediatrician or Internist	Visits 1-3: $50 copay, deductible waived; Visits 4+ member pays 100%. Aetna Pays 100% once out-of-pocket maximum is reached	50% after deductible
Specialist Visit	20% after deductible	50% after deductible (Non-designated and Out-of-Network providers)++
Hospital Admission	40% after deductible	50% after deductible (Non-designated and Out-of-Network providers)++
Outpatient Surgery	40% after deductible	50% after deductible (Non-designated and Out-of-Network providers)++
Urgent Care Facility	$100 copay deductible waived	50% after deductible
Emergency Room	$500 copay** (waived if admitted)	
Annual Routine Gyn Exam *No waiting period* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	20% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	40% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	20% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	20% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	40% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	Not Applicable	Not Applicable
Generic	$20 copay	$20 copay plus 50%
Preferred Brand	Not covered	Not covered
Non-Preferred Brand	Not covered	Not covered
Self-Injectables	Not covered	Not covered

* Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

\+ For important information on your costs and how Aetna pays for out-of-network care, read "What you need to know about your out-of-network costs."

++ For important information on what you will pay for Non-Designated and Out-of-Network Providers, read "How do the Savings Plus plans work"?

This plan provides preferred benefit coverage and access to covered services and supplies through a designated network of health care providers and facilities that are unique to your plan.

This Plan includes different benefit levels based upon the type of network provider that you use (designated or non-designated) or if you choose to see a non-preferred care provider. It is designed to lower your out-of-pocket costs when you use these designated network providers for covered expenses. These designated network providers are identified in the printed directory and the on-line version of the directory. Aetna also contracts with other network providers that are available to you under the plan (referred to as non-designated network providers), but your cost sharing will be at a much higher level when you use these providers.

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63.06.300.1-AZ C (10/12)

YOUR AETNA WHOLE HEALTH℠ **PLAN OPTION(S)**

COORDINATED CARE — QUALITY CARE, LOWER COST, AND AN ENHANCED PATIENT EXPERIENCE

FEATURING:

- Doctors in the network working together to build a care plan around you

AETNA WHOLE HEALTH℠ 1000

ARIZONA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	Maximum Savings	Out-of-Network+
Deductible Individual Family	$1,000 $2,000	$3,000 $6,000
Coinsurance (Member's responsibility)	30% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	$4,500 $9,000	$7,000 $14,000
Out-of-Pocket Maximum Individual Family	$5,500 $11,000	$10,000 $20,000
	Includes deductible	
Non-Specialist Office Visit *Unlimited visits* General Physician, Family Practitioner, Pediatrician or Internist	$30 copay deductible waived	50% after deductible
Specialist Visit *Unlimited visits*	$50 copay deductible waived	50% after deductible
Hospital Admission	30% after deductible	50% after deductible
Outpatient Surgery	30% after deductible	50% after deductible
Urgent Care Facility	$50 copay deductible waived	50% after deductible
Emergency Room	$500 copay** (waived if admitted)	
Annual Routine Gyn Exam *No waiting period* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	30% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	30% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	30% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	30% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	30% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	$500	$500
	Does not apply to generic	
Generic	$15 copay deductible waived	$15 copay plus 50% deductible waived
Preferred Brand	$45 copay after deductible	$45 copay plus 50% after deductible
Non-Preferred Brand	$70 copay after deductible	$70 copay plus 50% after deductible
Self Injectables	30% after deductible	Not covered

* Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

\+ For important information on your costs and how Aetna pays for out-of-network care, read "What you need to know about your out-of-network costs."

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63.06.300.1-AZ C (10/12)

Aetna®

AETNA WHOLE HEALTH℠ 2500

ARIZONA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	Maximum Savings	Out-of-Network+
Deductible Individual Family	 $2,500 $5,000	 $5,000 $10,000
Coinsurance (Member's responsibility)	30% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	 $5,000 $10,000	 $7,500 $15,000
Out-of-Pocket Maximum Individual Family	 $7,500 $15,000	 $12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit *Unlimited visits* General Physician, Family Practitioner, Pediatrician or Internist	$30 copay deductible waived	50% after deductible
Specialist Visit *Unlimited visits*	$50 copay deductible waived	50% after deductible
Hospital Admission	30% after deductible	50% after deductible
Outpatient Surgery	30% after deductible	50% after deductible
Urgent Care Facility	$50 copay deductible waived	50% after deductible
Emergency Room	$500 copay** (waived if admitted)	
Annual Routine Gyn Exam *No waiting period* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	30% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	30% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	30% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	30% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	30% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	$500	$500
	Does not apply to generic	
Generic	$15 copay deductible waived	$15 copay plus 50% deductible waived
Preferred Brand	$45 copay after deductible	$45 copay plus 50% after deductible
Non-Preferred Brand	$70 copay after deductible	$70 copay plus 50% after deductible
Self Injectables	30% after deductible	Not covered

* Maximum applies to combined in and out-of-network benefits.

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Aetna®

AETNA WHOLE HEALTH℠ 3500

ARIZONA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	Maximum Savings	Out-of-Network+
Deductible Individual Family	 $3,500 $7,000	 $7,000 $14,000
Coinsurance (Member's responsibility)	30% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	 $4,000 $8,000	 $5,500 $11,000
Out-of-Pocket Maximum Individual Family	 $7,500 $15,000	 $12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit *Unlimited visits* General Physician, Family Practitioner, Pediatrician or Internist	$30 copay deductible waived	50% after deductible
Specialist Visit *Unlimited visits*	$50 copay deductible waived	50% after deductible
Hospital Admission	30% after deductible	50% after deductible
Outpatient Surgery	30% after deductible	50% after deductible
Urgent Care Facility	$50 copay deductible waived	50% after deductible
Emergency Room	$500 copay** (waived if admitted)	
Annual Routine Gyn Exam *No waiting period* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	30% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	30% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	30% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	30% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	30% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	$500	$500
	Does not apply to generic	
Generic	$15 copay, deductible waived	$15 copay plus 50% deductible waived
Preferred Brand	$45 copay after deductible	$45 copay plus 50% after deductible
Non-Preferred Brand	$70 copay after deductible	$70 copay plus 50% after deductible
Self Injectables	30% after deductible	Not covered

* Maximum applies to combined in and out-of-network benefits.

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Aetna®

AETNA WHOLE HEALTH℠ 5000

ARIZONA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	Maximum Savings	Out-of-Network+
Deductible Individual Family	$5,000 $10,000	$10,000 $20,000
Coinsurance (Member's responsibility)	30% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	$5,000 $10,000	$2,500 $5,000
Out-of-Pocket Maximum Individual Family	$10,000 $20,000	$12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit *Unlimited visits* General Physician, Family Practitioner, Pediatrician or Internist	$30 copay deductible waived	50% after deductible
Specialist Visit *Unlimited visits*	$50 copay deductible waived	50% after deductible
Hospital Admission	30% after deductible	50% after deductible
Outpatient Surgery	30% after deductible	50% after deductible
Urgent Care Facility	$50 copay deductible waived	50% after deductible
Emergency Room	$500 copay** (waived if admitted)	
Annual Routine Gyn Exam *No waiting period* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	30% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	30% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	30% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	30% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	30% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	$500	$500
	Does not apply to generic	
Generic	$15 copay deductible waived	$15 copay plus 50% deductible waived
Preferred Brand	$45 copay after deductible	$45 copay plus 50% after deductible
Non-Preferred Brand	$70 copay after deductible	$70 copay plus 50% after deductible
Self Injectables	30% after deductible	Not covered

* Maximum applies to combined in and out-of-network benefits.

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Aetna®

INDIVIDUAL DENTAL PPO MAX PLAN **PLAN OPTION**

INDIVIDUAL DENTAL PPO MAX PLAN

ARIZONA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	Preferred	Non-Preferred+
Annual Deductible per Member (Does not apply to Diagnostic and Preventive Services)	$25; $75 family maximum	$25; $75 family maximum
Annual Maximum Benefit	Unlimited	Unlimited
DIAGNOSTIC SERVICES		
Oral exams		
Periodic oral exam	100% deductible waived	50% deductible waived
Comprehensive oral exam	100% deductible waived	50% deductible waived
Problem-focused oral exam	100% deductible waived	50% deductible waived
X-rays		
Bitewing — single film	100% deductible waived	50% deductible waived
Complete series	100% deductible waived	50% deductible waived
PREVENTIVE SERVICES		
Adult cleaning	100% deductible waived	50% deductible waived
Child cleaning	100% deductible waived	50% deductible waived
Sealants — per tooth	Not covered	Not covered
Fluoride application — with cleaning	100% deductible waived	50% deductible waived
Space maintainers	Not covered	Not covered
BASIC SERVICES		
Amalgam fillings — 2 surfaces	100% after deductible	50% after deductible
Resin fillings — 2 surfaces	Not covered	Not covered
Oral Surgery		
Extraction — exposed root or erupted tooth	Not covered	Not covered
Extraction of impacted tooth — soft tissue	Not covered	Not covered
MAJOR SERVICES		
Complete upper denture	Not covered	Not covered
Partial upper denture (resin based)	Not covered	Not covered
Crown — Porcelain with noble metal	Not covered	Not covered
Pontic — Porcelain with noble metal	Not covered	Not covered
Inlay — Metallic (3 or more surfaces)	Not covered	Not covered
Oral Surgery		
Removal of impacted tooth — partially bony	Not covered	Not covered
Endodontic Services		
Bicuspid root canal therapy	Not covered	Not covered
Molar root canal therapy	Not covered	Not covered
Periodontic Services		
Scaling & root planing — per quadrant	Not covered	Not covered
Osseous surgery — per quadrant	Not covered	Not covered
ORTHODONTIC SERVICES	Not covered	Not covered

This list of covered services is representative. A summary of exclusions is listed in the Aetna Advantage Plan brochure. For a full list of benefit coverage and exclusions refer to the plan documents.

All products not available in all counties.

This material is for information only. Dental insurance plans contain exclusions and limitations. Not all dental services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Information is believed to be accurate as of the production date; however, it is subject to change.

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+ For important information on your costs and how Aetna pays for out-of-network care, read "What you need to know about your out-of-network costs."

63.06.300.1-AZ C (10/12)

WHAT YOU NEED TO KNOW ABOUT **YOUR OUT-OF-NETWORK COSTS**

We cover the cost of care differently based on whether health care providers, such as doctors and hospitals, are "in network" or "out of network." We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this out-of-network care.

As an example, you may choose a doctor in our network. You may choose to visit an out-of-network doctor. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill.

Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount. For medical plans, Aetna recognizes an amount based on what Medicare pays for these services. The government sets the Medicare rate.

Your out-of-network doctor sets the rate to charge you. It may be higher—sometimes much higher—than what your Aetna plan "recognizes" or "allows."

Your doctor may bill you for the dollar amount that Aetna doesn't recognize. You must also pay any copayments, coinsurance and deductibles under your plan.

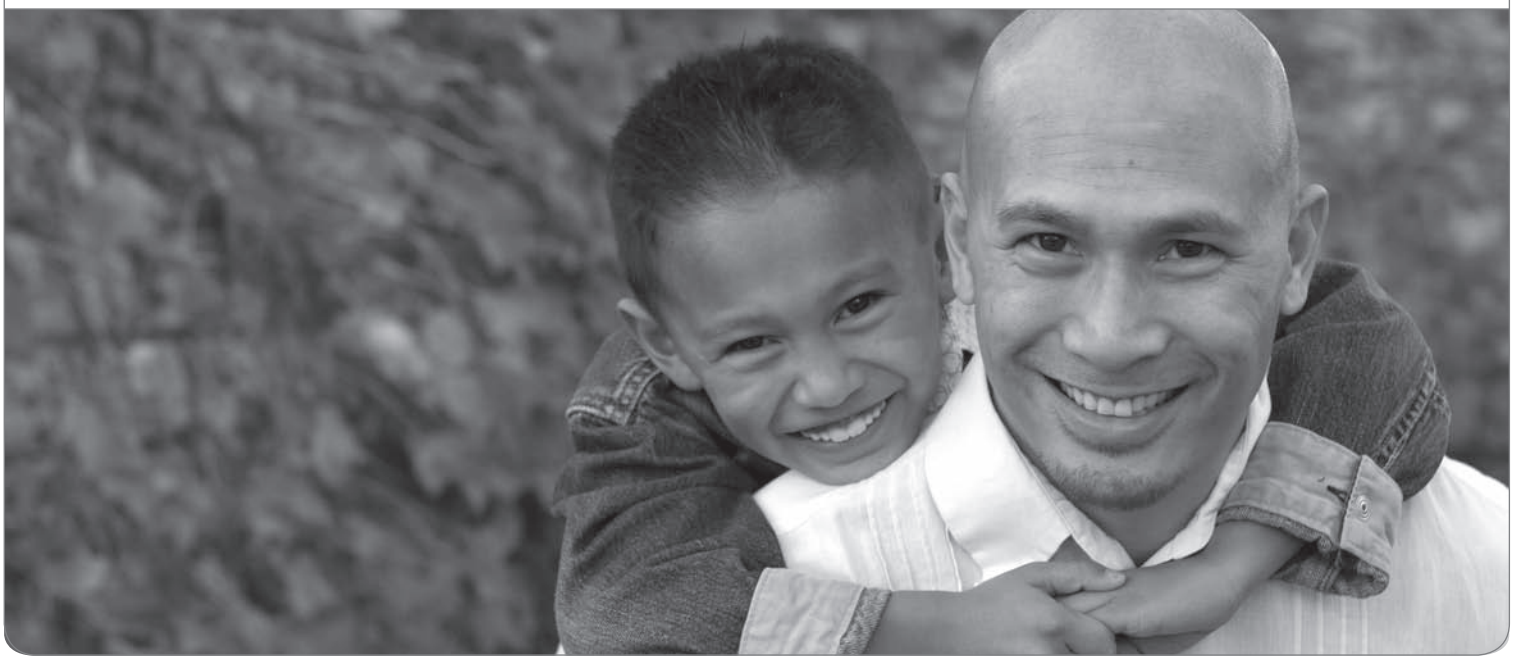
No dollar amount above the recognized charge counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit **www.Aetna.com**. Type "how Aetna pays" in the search box.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to **www.Aetna.com** and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna Navigator member site.

This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance and deductibles for your in-network level of benefits. Contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments, coinsurance and deductibles.

For dental plans, your share of costs for care is determined in a similar way as your medical plan, which is outlined in detail above. If you choose an out-of-network dentist, you will pay a lot more money out of your own pocket most of the time.

But the amount Aetna recognizes for out-of-network dentists is based on different rates than the medical plan. Aetna bases payments to out-of-network dentists on rates we use to begin contract negotiations with dentists in our network.



HOW DO THE SAVINGS PLUS PLANS WORK?

THE AETNA SAVINGS PLUS PLANS† OFFER YOU ACCESS TO HEALTH SERVICES THAT FIT YOUR NEEDS AND BUDGET. THEY GIVE YOU ACCESS TO AN AFFORDABLE NETWORK OF HEALTH PROVIDERS IN YOUR OWN COMMUNITY.

The Aetna Savings Plus insurance plans provide you with the same types of coverage as other Aetna medical plans, but at a lower premium cost. Savings are generated by using the Savings Plus network, a network of local health care providers.

The plans also:

- cover doctor's visits, hospital stays and preventive care.
- include prescription drugs.
- provide access to a secure member self-service website.

Each Savings Plus plan has three levels of benefits:

- **Level 1:** when you use the Savings Plus network, you realize **maximum savings**.
- **Level 2:** when you use the non-designated network providers, you realize **standard savings.**
- **Level 3:** when you use out-of-network providers, you will pay the **highest member cost.**

You have the freedom to receive care from any hospital or specialist. However, you realize the highest benefit level and the lowest out-of-pocket costs when you access care through the Savings Plus network.

All Savings Plus plans include coverage for doctor visits, hospital stays, preventive care, pharmacy and more.

Premiums and out-of-pocket expense levels vary. So select the plan that's right for you and your family.

EXAMPLE

The following is an example* of what you might typically pay for each of the levels based on which network you choose.

	Maximum savings	Non-designated provider	Out-of-network provider
Cost of service	$1,750	$1,750	$1,750
Aetna's negotiated rate/ recognized amount	$1,000	$1,000	N/A
Amount covered by your plan (Aetna pays)	$800	$500	$500
Coinsurance (you pay)	$200	$500	$500
Amount that can be balance billed to you	$0	$0	$750
TOTAL COST YOU ARE RESPONSIBLE TO PAY	**$200**	**$500**	**$1,250**

* This is an example of how the Savings Plus plans work after a member meets their deductible.

†This plan provides preferred benefit coverage and access to covered services and supplies through a designated network of health care providers and facilities that are unique to your plan.

This Plan includes different benefit levels based upon the type of network provider that you use (designated or non-designated) or if you choose to see a non-preferred care provider. It is designed to lower your out-of-pocket costs when you use these designated network providers for covered expenses. These designated network providers are identified in the printed directory and the on-line version of the directory. Aetna also contracts with other network providers that are available to you under the plan (referred to as non-designated network providers), but your cost sharing will be at a much higher level when you use these providers.

AETNA WHOLE HEALTH℠
BANNER HEALTH NETWORK

AVAILABLE IN THE GREATER PHOENIX METROPOLITAN AREA

Your care. Your choice.

There are many choices in health care. Sometimes it's hard to know the best option for you and your family. But it's important to know that you have the power to choose and make decisions about your care.

Luckily, you have access to Banner Health Network. Using these doctors and hospitals means your care is coordinated by a team of doctors. They work to give you quality care at an affordable cost.

Use Banner Health Network for coordinated care

Why does coordinated care matter?

Coordinated care helps doctors provide care more effectively. They communicate better with you and other doctors in the network.

Doctors in the network work together to build a care plan around you. And they share information about your care more easily with each other.

Coordinated care is simply more effective and efficient. It can cut down on duplicate medical tests and other things that increase your costs.

You can still visit hospitals and doctors not in Banner Health Network. But when you use Banner Health Network, there is a good chance that your care could cost you less.

More ways to get care

While using doctors and hospitals in the network is a good idea, sometimes you may need to seek other types of care.

- If you have an emergency, you can go to any hospital.
- You can use any walk-in clinic in the Aetna network.

Need special care? Look for Institutes of Excellence™ facilities and Institutes of Quality® facilities for infertility, transplants and more.

LOOK FOR THE AETNA WHOLE HEALTH SYMBOL WHEN YOU CHOOSE A DOCTOR, SPECIALIST OR HOSPITAL.

HOW TO FIND COORDINATED CARE

Use Banner Health Network doctors and hospitals

Visit **www.aetna.com/docfind/custom/bannerhealthnetwork.**

Look for doctors and hospitals that have the Aetna Whole Health℠ symbol. Ⓐ

Choose health care facilities that work for your needs

Sometimes, you don't need to receive care at a hospital. Check DocFind for X-ray, lab and ambulatory surgery centers in your network. They can provide the right care for you, at the right cost for your health care budget.

Use our online tools

You can compare costs for many health care services. When you know costs, you can make the most out of your benefits. This can help you save.

- See what you'll pay for hundreds of doctor and hospital services in most parts of the country, based on your actual health benefits and insurance plan. Compare estimates for up to 10 doctors or hospitals at a time.*
- Compare in- and out-of-network cost estimates for office visits, surgeries, medical tests and more.
- Look up costs for prescription drugs — before you fill a prescription. And find out what you can save by using our home delivery service.

* Estimated costs not available in all markets. Actual costs may differ for a number of reasons, including if other or different services are performed by the doctor or facility at the time of your visit, and/or additional claims/member payments are processed before the actual claim for the estimated service is processed.

FOR MORE INFORMATION ABOUT AETNA WHOLE HEALTH AND HOW YOU CAN IMPROVE YOUR HEALTH WHILE LOWERING YOUR HEALTH CARE COSTS, PLEASE VISIT **WWW.AETNAINDIVIDUAL.COM** OR CALL **1-800-MY-HEALTH (1-800-694-3258)**.

HOW CAN I GET PERSONALIZED **HEALTH INFORMATION — IN ONE SEARCH?**

Aetna SmartSource℠ delivers health information that's specific to each member, based on where you live, your Aetna health plan, and other information. Whether researching a condition, symptom, procedure or other health topic, Aetna SmartSource scans Aetna's vast resources to bring you, in a single search:

- Specialists in your local area
- Related medications, treatment options and estimated health costs
- Aetna programs that may help you manage a condition
- Easy-to-understand health articles and tips

You can access Aetna SmartSource through Aetna Navigator®, or your Personal Health Record, if these tools are available to you.

THINGS YOU **NEED TO KNOW**

To qualify for an Aetna Advantage Plan, you must be:

- At least age 19 and under age 64 3/4 (If applying as a couple, both you and your spouse must be at least age 19 and under 64 3/4)
- Legal residents in a state with products offered by the Aetna Advantage Plans
- Legal U.S. residents for at least six continuous months

If you qualify for an Aetna Advantage Plan, we offer dependent coverage under your policy for dependent children up to age 26 (except in Florida and Nebraska, where dependent coverage is up to age 30; and in Ohio, where dependent coverage is up to age 28).

MEDICAL UNDERWRITING REQUIREMENTS

The Aetna Advantage Plans are not guaranteed issue plans and require medical underwriting. Some individuals may qualify as eligible under the Health Insurance Portability Accountability Act (HIPAA) for guaranteed issue plans.

All applicants, enrolling spouses and dependents are subject to medical underwriting to determine eligibility and appropriate premium rate level.

We offer various premium rate levels based on the medical underwriting of each applicant.

YOUR PREMIUM PAYMENTS

Your premium rate is guaranteed for the initial 12 months of your policy provided that there are no changes to your policy, including your area of residence, benefit plan or addition of dependents. However, if there is a change in law or regulation or a judicial decision that has an impact on the cost of providing your covered benefits under your policy, we reserve the right to change your premium rate during this guarantee period.

63.44.316.1 (1/11)

10-DAY RIGHT TO REVIEW

Do not cancel your current insurance until you are notified that you have been accepted for coverage. We'll review your enrollment form or application to determine if you meet underwriting requirements. If your application or enrollment form is denied, you'll be notified by mail. If your application or enrollment form is approved, you'll be notified by mail and sent an Aetna Advantage Plan contract and ID card.

If, after reviewing the contract, you find that you're not satisfied for any reason, simply return the contract to us within 10 days. We will refund any premium you've paid (including any contract fees or other charges) less the cost of any medical or dental services paid on behalf of you or any covered dependent.

YOUR COVERAGE REMAINS IN EFFECT AS LONG AS YOU PAY THE REQUIRED PREMIUM CHARGES ON TIME, AND AS LONG AS YOU MAINTAIN ELIGIBILITY IN THE PLAN.

CONVENIENT PREMIUM PAYMENTS

You can make simple automatic payments via Electronic Funds Transfer (EFT) or by Visa, MasterCard or American Express credit cards.

Registration: Complete the payment section of the Aetna Advantage Plans enrollment form or application. Select the appropriate payment method (EFT or credit card) to approve the automatic withdrawal of your initial premium and all subsequent premium payments. (Please note: The initial premium payment is debited UPON APPROVAL of your application).

Invoices: You will not receive a paper invoice when you are enrolled in EFT. Payments will appear on your bank statement as "Aetna Autodebit Coverage."

Terminating: To terminate EFT or the automatic credit card payment option, Aetna requires 10 days written notice before the date your next scheduled payment is due to be processed. Without this written notice, your bank account or credit card may be debited for the next month's premium payment. You would then need to contact us to have a refund processed to your bank account or credit card.

Refunds: To process an EFT refund (placing money back in member's checking account), we need at least five days after the withdrawal was made to ensure valid payment. Credit card refunds will be returned to the credit card charged within 3-5 business days from the date it is processed.

Rejected transactions: If the EFT (checking account) or credit card payment rejects for any reason, we will send you a letter requesting corrected information. If we receive corrected information, you will have the full amount due debited on the next billing cycle. If you fail to send corrected information, we will continue to attempt to debit your bank account or charge your credit card for the full amount due. Failure to supply correct account information may result in your policy being terminated for non-payment.

Timing: Please note the following dates when automatic payments are processed:

- Payments for Cycle 1 accounts (1st of the month effective date):
  - EFT (checking accounts) will be debited between the 3rd and 10th of each month the premium is due.
  - Credit Cards will be debited between the 5th and 12th of each month the premium is due.
- Payments for Cycle 2 accounts (15th of the month effective date):
  - EFT (checking accounts) will be debited between the 18th and 23rd of each month the premium is due.
  - Credit Cards will be debited between the 20th and 25th of each month the premium is due.

YOUR COVERAGE

Your coverage remains in effect as long as you pay the required premium charges on time, and as long as you maintain eligibility in the plan. Coverage will be terminated if you become ineligible due to any of the following circumstances:

- Non-payment of premiums
- Becoming a resident of a state or location in which Aetna Advantage Plans are not available
- Obtaining duplicate coverage
- For other reasons permissible by law

Levels of coverage and enrollment

These plans are subject to medical underwriting. To the extent that you are subject to medical underwriting, the following may occur once we have evaluated your application or enrollment form:

- You may be enrolled in your selected plan at the lowest rate available (known as the standard premium charge)
- You may be enrolled in your selected plan at a higher premium
- You may be declined coverage (except for dependents under age 19)

Duplicate coverage

If you are currently covered by another carrier, you must agree to discontinue the other coverage before or on the effective date of the Aetna Advantage Plan. However, do not cancel your current insurance until you are notified that you have been accepted for coverage and are certain that you are keeping your Aetna Advantage Plan coverage.

LIMITATIONS & EXCLUSIONS

Medical

These medical plans do not cover all health care expenses and include 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 partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s). Services and supplies that are generally not covered include, but are not limited to:

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents, including costs of services before coverage begins and after coverage terminates
- Cosmetic surgery
- Custodial care
- Donor egg retrieval
- Infertility services and other related reproductive services unless specifically listed as covered in your plan documents
- Over-the-counter medications and supplies
- Weight control services including surgical procedures for the treatment of obesity, medical treatment, and weight control/loss programs
- Experimental and investigational procedures, (except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial)
- Charges in connection with pregnancy care other than for pregnancy complications (unless otherwise mandated by your state)
- Immunizations for travel or work
- Implantable drugs and certain injectable drugs including injectable infertility drugs
- Orthotics
- Radial keratotomy or related procedures
- Reversal of sterilization
- Services, supplies or counseling related to the treatment of sexual dysfunction
- Special or private duty nursing
- Therapy or rehabilitation other than those listed as covered in the plan documents
- Mental health and substance abuse coverage (unless otherwise mandated by your state)

Dental

Listed below are some of the charges and services for which our dental plans do not provide coverage.
For a complete list of exclusions and limitations, refer to plan documents.

- Dental services or supplies that are primarily used to alter, improve or enhance appearance (negotiated rates for cosmetic procedures may be available when a participating dentist is accessed)
- Experimental services, supplies or procedures
- Treatment of any jaw joint disorder, such as temporomandibular joint disorder
- Replacement of lost or stolen appliances and certain damaged appliances
- Services that Aetna defines as not necessary for the diagnosis, care or treatment of a condition involved
- All other limitations and exclusions in your plan documents

PRE-EXISTING CONDITIONS

For Applicants 19 and older: During the first 12 months* following your effective date of coverage, no coverage will be provided for the treatment of a pre-existing condition unless you have prior creditable coverage.

A pre-existing condition is an illness, disease, physical condition, or injury for which medical advice, or treatment was recommended or received and/or the use of prescription drugs of any kind within six months preceding the effective date of coverage. Services or supplies for the treatment of a pre-existing condition are not covered for the first 12 months after the member's effective date. If the member had continuous prior creditable coverage within the 63 days** immediately preceding the signature on the application and meets certain other requirements, then the pre-existing condition exclusion of 12 months* may not apply.

* Six months in California
** 90 days in Alaska, Colorado and Wyoming; 120 days in Connecticut

WANT TO MAKE THE MOST OF YOUR MONEY? **THE MORE YOU KNOW, THE BETTER IT GETS.**

Compare and save with the Member Payment Estimator

Before thinking about health care services, you should know what they will cost. With this tool, you can find out what you'll be paying, what you're getting and what you can expect when you have office visits or tests. By planning ahead, you can get the most from your money.

No matter where you are or what time of day, we've designed helpful and practical tools to make your life a little easier. It's what we call people care.

- Review costs for tests and procedures by type and locations
- See cost details based on your health insurance plan, including copays and deductibles
- Access the comparison feature so you can shop around
- Get ready for your upcoming procedure with helpful advice

Explore a smarter health plan.
Visit us at **www.aetna.com**.

IMPORTANT DISCLOSURE INFORMATION FOR ARIZONA

FOR MANAGED CHOICE®, ELECT CHOICE®, OPEN CHOICE®
AND AETNA OPEN ACCESS® PLANS.

PLAN BENEFITS

The plan you choose is underwritten or administered by Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, CT 06156, 1-888-982-3862. Covered services include most types of treatment provided by primary care physicians, specialists and hospitals. However, a health plan excludes and/or includes limits on coverage for some services, including but not limited to, cosmetic surgery and experimental procedures. In addition, in order to be covered, all services, including the location (type of facility), duration and costs of services, must be medically necessary as defined below and as determined by Aetna. The information that follows provides general information regarding Aetna health plans. For a complete description of the benefits available to you, including procedures to follow, exclusions and limitations, refer to your specific plan documents, which may include the Booklet-certificate, Group Agreement, Group Insurance Certificate, Group Policy and any applicable riders and amendments to your plan.

MEMBER COST SHARING

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

- Copay – This may be a flat fee that you pay directly to the health care provider at the time of service.
- Coinsurance – This is a percentage of the fees that you must pay toward the cost of some covered medical expenses. Your health care provider will bill you for this amount.
- Calendar Year Deductible – The amount of covered medical expenses you pay each calendar year before benefits are paid. There is a calendar-year deductible that applies to each person.
- Inpatient Hospital Deductible – The amount of covered inpatient hospital expenses you pay for each hospital confinement before benefits are paid. This deductible is in addition to any other copayments or deductibles under your plan.
- Emergency Room Deductible – The amount of covered hospital emergency room expenses you pay each year before benefits are paid. A separate hospital emergency room deductible applies to each visit by a person to a hospital emergency room unless the person is admitted to the hospital as an inpatient within 24 hours after a visit to a hospital emergency room.

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

HAVE A STUDENT PLAN?

If you have a Student Accident and Sickness plan please visit **www.aetnastudenthealth.com** for questions or call Aetna Student Health at the toll-free number on your ID card for more information. For appeals, please forward your request to Chickering Claims Administrators, Inc.*, P.O. Box 15717, Boston, MA 02215-0014. Fully insured student health insurance plans are underwritten by Aetna Life Insurance Company (ALIC) and administered by Chickering Claims Administrators, Inc. (CCA). Self-insured plans are funded by the applicable school, with claims administration services provided by Chickering Claims Administrators, Inc. Aetna Student Health is the brand name for products and services provided by ALIC and CCA.

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* The Chickering Group refers to an internal business unit of Chickering Claims Administrators, Inc. The Student Plan is underwritten by Aetna Life Insurance Company and administered by Chickering Claims Administrators, Inc.

YOUR PRIMARY CARE PHYSICIAN

Check your plan documents to see if your plan requires you to select a primary care physician (PCP). If a PCP is required, you must choose a doctor from the Aetna network. You can look up network doctors in a printed Aetna Physician Directory, or visit our DocFind® directory at **www.aetna.com**. If you do not have Internet access and would like a printed directory, please contact Member Services at the toll-free number on your ID card and request a copy.

You may choose a different PCP for each member of your family. When you enroll, indicate the name of the PCP you have chosen on your enrollment form. Or, call Member Services after you enroll to tell us your selection. The name of your PCP will appear on your Aetna ID card. You may change your selected PCP at any time. If you change your PCP, you will receive a new ID card.

Your PCP can provide primary health care services as well as coordinate your overall care. You should consult your PCP when you are sick or injured to help determine the care that is needed. If your plan requires referrals, your PCP should issue a referral to a participating specialist or facility for certain services. (See Referral Policy for details.)

REFERRAL POLICY

Check your plan documents to see if your plan requires PCP referrals for specialty care. If referrals are required, you must see your PCP first before visiting a specialist or other outpatient provider for nonemergency or nonurgent care. Your PCP will issue a referral for the services needed.

If you do not get a referral when a referral is required, you may have to pay the bill yourself, or the service will be treated as nonpreferred if your plan includes out-ofnetwork benefits. Some services may also require prior approval by us. See the Precertification section and your plan documents for details.

The following points are important to remember regarding referrals.

- The referral is how your PCP arranges for you to be covered at the in-network benefit level 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 beyond those referred by the PCP, you may need to get another referral from your PCP before receiving the services.
- Except in emergencies, all inpatient hospital services require a prior referral from your PCP and prior authorization by Aetna.
- Referrals are valid for one year as long as you remain an eligible member of the plan; the first visit must be within 90 days of referral issue date.
- In plans without out-of-network benefits, coverage for services from nonparticipating providers requires prior authorization by Aetna in addition to a special nonparticipating referral from the PCP. When properly authorized, these services are fully covered, less the applicable cost sharing.
- The referral (and a precertification, if required) provides that, except for applicable cost sharing (that is, copays, coinsurance and/or deductibles), you will not have to pay the charges for covered expenses, as long as the individual seeking care is a member at the time the services are provided.

DIRECT ACCESS OB/GYN PROGRAM

This program allows female members to visit without a referral any participating obstetrician or gynecologist for a routine breast exam, mammogram and 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 also 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 that organization may have different referral policies.

PRODUCT	PCP REQUIRED?	REFERRALS REQUIRED?	PRECERTIFICATION REQUIRED?
Open Choice	No	No	Yes
Managed Choice	Yes	Yes	Yes
Aetna Open Access Managed Choice	Encouraged	No	Yes
Elect Choice	Yes	Yes	Yes
Aetna Open Access Elect Choice	Encouraged	N/A	Yes

PRECERTIFICATION

Some health care services, like hospitalization and certain outpatient surgery, require "precertification." This means the service must be approved by Aetna before it will be covered under the plan. Check your plan documents for a complete list of services that require this approval.

When reviewing a precertification request, we will verify your eligibility and make sure the service is a covered expense under your plan. We also check the cost-effectiveness of the service and we may communicate with your doctor if necessary. If you qualify, we may enroll you in one of our case management programs and have a nurse call to make sure you understand your upcoming procedure. When you visit a doctor, hospital or other provider that participates in the Aetna network, someone at the provider's office will contact Aetna on your behalf to get the approval.

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

You cannot request precertification after the service is performed. To precertify services, call the number shown on your Aetna ID card. In plans that do not have out-ofnetwork benefits, coverage for services from nonparticipating providers requires prior authorization by Aetna in addition to a special nonparticipating referral from the PCP. When properly authorized, these services are fully covered, less the applicable cost sharing.

HEALTH CARE PROVIDER NETWORK

All hospitals may not be considered Aetna participating providers for all the services that you need. Your physician can contact Aetna to identify a participating facility for your specific needs. Certain PCPs are affiliated with IDSs, IPAs or other provider groups. If you select one of 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 Aetna network providers that are not affiliated with the organization. In order to be covered, services provided by network providers that are not affiliated with the organization may require prior authorization from Aetna and/or the IDS or other provider groups. You should note that other health care providers (e.g. specialists) may be affiliated with other providers through organizations.

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

ADVANCE DIRECTIVES

There are three types of advance directives:

- Durable power of attorney – appoints someone you trust to make medical decisions for you.
- Living will – spells out the type and extent of care you want to receive.
- Do-not-resuscitate order – states that you don't want to be given CPR if your heart stops or be intubated 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.
- If you are not satisfied with the way Aetna handles advance directives, you can file a complaint with your Medicare State Certification Agency. Visit **www.medicare.gov** for information on specific state agencies or call 1-800-MEDICARE (1-800-633-4227) (TTY/TDD: 1-877-486-2048).

Source: American Academy of Family Physicians. *Advanced Directives and Do Not Resuscitate Orders.* January 2009. Available at http://familydoctor.org/003.xml?printxml. Accessed February 20, 2009.

TRANSPLANTS AND OTHER COMPLEX CONDITIONS

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

Note: There are exceptions depending on state requirements.

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 person, 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 doctor or PCP. Notify your doctor or 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 doctor, 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 bleeding, severe vomiting 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, we may ask you for more information to qualify the coverage. We will send you an Emergency Room Notification Report to complete, or a Member Services representative can take this information by telephone.

After-Hours Care

You may call your provider'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. See your plan documents for cost-sharing provisions for urgent care services.

PRESCRIPTION DRUGS

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

Your prescription drug benefit is generally not limited to drugs listed on the preferred drug list. Medications that are not listed on the preferred drug list (nonpreferred or nonformulary drugs) may be covered subject to the limits and exclusions set forth in your plan documents.

Covered nonformulary prescription drugs may be subject to higher copayments or coinsurance under some benefit plans. Some prescription drug benefit plans may exclude from coverage certain nonformulary drugs that are not listed on the preferred drug list. If it is medically necessary for you to use such drugs, your physician, you or your authorized representative (or pharmacist in the case of antibiotics and analgesics) may contact Aetna to request coverage as a medical exception. Check your plan documents for details.

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

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

Ask your treating physician(s) about specific medications. Refer to your plan documents or contact Member Services for information regarding terms, conditions and limitations of coverage. If you use the Aetna Rx Home Delivery® mailorder prescription program or the Aetna Specialty Pharmacy® specialty drug program, you will be acquiring these prescriptions through an affiliate of Aetna. Aetna Rx Home Delivery's and Aetna Specialty Pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts they may receive from wholesalers, manufacturers, suppliers and distributors. The negotiated charge with Aetna Rx Home Delivery, LLC. and Aetna Specialty Pharmacy may be higher than the cost of purchasing drugs and providing pharmacy services.

Updates to the Drug Formulary

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

BEHAVIORAL HEALTH NETWORK

Behavioral health care services are managed by Aetna. As a result, Aetna is responsible for making initial coverage determinations and coordinating referrals to the Aetna provider network. 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 on the terms of your health plan and state law. If your health plan includes behavioral health services, you may be covered for mental health conditions and/or drug and alcohol abuse services, including inpatient and outpatient services, partial hospitalizations and other behavioral health services. You can determine the type of behavioral health coverage available under the terms of your plan and how to access services by calling the Aetna Member Services number listed on your ID card.

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

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

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

BEHAVIORAL HEALTH PROVIDER SAFETY DATA AVAILABLE

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

BEHAVIORAL HEALTH DEPRESSION PREVENTION PROGRAMS

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

HOW AETNA PAYS IN-NETWORK PROVIDERS

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

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

HOW AETNA PAYS OUT-OF-NETWORK PROVIDERS

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

Prevailing Charge Plans

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

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

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

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

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

Step 3: We refer to your health plan.
We pay our portion of the prevailing charge as listed in your health plan. You pay your portion (called "coinsurance") and any deductible. For example, your out of network doctor charges $120 for an office visit. Your plan covers 70 percent of the "reasonable," "usual and customary" or "prevailing" charge. Let's say the prevailing charge is $100. And let's say you already met your deductible. Aetna would pay $70. You would pay the other $30. Your doctor may also bill you for the $20 difference between the prevailing charge ($100) and the billed charge ($120). In this case, your doctor could bill you for a total of $50.

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

Fee Schedule Plans

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

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

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

Exceptions
Some "prevailing charge" plans set the prevailing charge at a different percentile. For some claims (like those from hospitals and outpatient centers) we may use other information and data sources to determine the charge.

And some of our plans pay based on a different kind of fee schedule. Also, for some non-participating providers we may pay based on other contractual arrangements. Our provider claims codes and payment policies may also affect what we pay for a claim. Aetna may use computer software (including ClaimCheck®) and other tools to take into account factors such as the complexity, amount of time needed and manner of billing. The effects of these policies will be reflected in your Explanation of Benefits documents.

HOW AETNA PAYS FOR OUT-OF-NETWORK BEHAVIORAL HEALTH BENEFITS

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

TECHNOLOGY REVIEW

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

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

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

MEDICALLY NECESSARY

"Medically necessary" means that the service or supply is provided by a physician or other health care provider exercising prudent clinical judgment for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that provision of the service or supply is:

- In accordance with generally accepted standards of medical practice; and
- Clinically appropriate in accordance with generally accepted standards of medical practice in terms of type, frequency, extent, site and duration, and considered effective for the illness, injury or disease; and
- Not primarily for the convenience of you, or for the physician or other health care provider; and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the illness, injury or disease.

For these purposes "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

CLINICAL POLICY BULLETINS

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

Aetna CPBs do not constitute medical advice. Treating providers are solely responsible for medical advice and for your treatment. You should discuss any CPB related to your coverage or condition with your treating provider. While Aetna 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 CPBs are available at **www.aetna.com** under "Members" and then "Health Coverage Information." If you do not have Internet access, please contact Member Services at the toll-free number on your ID card for information about specific Clinical Policy Bulletins.

UTILIZATION REVIEW/ PATIENT MANAGEMENT

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

Concurrent review is a review conducted while a patient is confined on an inpatient basis. 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 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 that may to be utilized by you upon discharge from an inpatient stay.

Retrospective Record Review
Retrospective review is a review conducted after the patient has been discharged from the hospital or facility. The purpose of retrospective review is to 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. Our 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.

COMPLAINTS, APPEALS AND EXTERNAL REVIEW

This Complaint Appeal and External Review process may not apply if your plan is self-funded. Contact your Benefits Administrator if you have any questions.

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

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

About Coverage Decisions
Sometimes we receive claims for services that may not be covered by your health benefits plan. It can be confusing — even to your doctors. Our job is to make coverage decisions based on your specific benefits plan. If a claim is denied, we'll send you a letter to let you know. If you don't agree you can file an appeal. To file an appeal, follow the directions in the letter that explains that your claim was denied. Our appeals decisions will be based on your plan provisions and any state and federal laws or regulations that apply to your plan. You can learn more about the appeal procedures for your plan from your plan documents.

External Review
We established an external review process to give you the opportunity of requesting an objective and timely independent review of certain coverage denials. Standards may vary by state, and several states have external review processes that may apply to your plan.

If a request meets the requirement for an external review, an Independent Review Organization (IRO) will assign the case to an external physician reviewer with appropriate expertise for an independent decision 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 your physician certifies that a delay in service would jeopardize your health.

Once the review is complete, the plan will abide by the decision of the external reviewer. The cost for the review will be borne by Aetna (except where state law requires you to pay a filing fee as part of a state mandated program).

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

MEMBER RIGHTS & RESPONSIBILITIES

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

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 email us from your secure Aetna Navigator member website at **www.aetna.com**. Click on "Contact Us" after you log on.

Spanish-speaking hotline – 1-800-533-6615

Multilingual hotline – 1-888-982-3862 (140 languages are available. You must ask for an interpreter.)

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

TDD Member Services – 1-800-628-3323 (hearing impaired only)

QUALITY MANAGEMENT PROGRAMS

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

PRIVACY NOTICE

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

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

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

To request a printed copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please write to:

Aetna Legal Support Services Department
151 Farmington Avenue, W121
Hartford, CT 06156

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

NON-DISCRIMINATION STATEMENT

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

USE OF RACE, ETHNICITY AND LANGUAGE DATA

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

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

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

IF YOU ARE ENROLLED IN A GROUP HEALTH PLAN, 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 to 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 to 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 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 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 listed on your ID card.

NOTICE REGARDING WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

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

(3) prostheses; and

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

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

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

STATE DISCLOSURES

SCALP HAIR PROSTHESIS

(applies only to the states listed below)

In AK, AZ, DC, DE, IL, IN, MO , OH, PA, TN, AND VA, Aetna will provide coverage for expenses for a scalp hair prosthesis worn for hair loss suffered as a result of alopecia areata, resulting from an autoimmune disease. The same limitations and guidelines that apply to other prosthesis as outlined in your Benefit Plan will apply to scalp hair prosthesis as a result of alopecia areata.

Health benefits and health insurance plans are underwritten or administered by Aetna Life Insurance Company. 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 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 accreditation status can be found on the NCQA website located at **http://www.ncqa.org/tabid/142/Default.aspx.**

To refine your search, we suggest you search these areas: **Managed Behavioral Healthcare Organizations** – for behavioral health accreditation; Credentials Verification Organizations – for credentialing certification; **Managed Care Organizations** – for HMO and PPO health plan accreditation; **Recognition Directory** – for physicians recognized by NCQA in the areas of heart/stroke care, diabetes care, back pain and systematic processes.

Health care providers who have been duly recognized by the NCQA Recognition Programs are annotated in the Physician 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. 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 **www.ncqa.org/tabid/58/Default.aspx**. If you do not have access to the Internet and would like a printed physician directory, please contact Member Services at the toll-free number shown on your Aetna ID card.

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 602-364-2499 or 602-364-2496 or 1-800-325-2548 (inside Arizona but outside the Phoenix area), or you may call us at 1-800-756-7039.

HOW TO KNOW WHEN YOU CAN APPEAL

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

DECISIONS YOU CAN APPEAL

You can appeal the following decisions:

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

DECISIONS YOU CANNOT APPEAL

You cannot appeal the following decisions:

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

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

WHO CAN FILE AN APPEAL

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

DESCRIPTION OF THE APPEALS PROCESS

I. Levels of Review

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

Each type of appeal has three levels, as follows:

Expedited Appeals
(For urgently needed services you have not yet received)

Standard Appeals
(For non-urgent services or denied claims)

Level One: Expedited Appeal
Formal Appeal

Level Three: Expedited External, Independent Medical Review
External, Independent Medical Review

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

EXPEDITED APPEAL PROCESS FOR URGENTLY NEEDED SERVICES NOT YET PROVIDED

Expedited Appeal (Level One)

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

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

Name: Aetna Life Insurance Company
Title: Customer Resolution Team
Address: P.O. Box 14002, Lexington, KY 40512
Phone: 1-877-665-6736
Fax: 860-754-5321

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

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

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

Expedited External, Independent Review (Level Two)

Once you have completed the appeal process with Aetna, you may request an external review.

External reviews are conducted by independent physicians with expertise in the medical service or supply at issue. Once a review is complete, Aetna accepts the decision of the external reviewer.

Once you are eligible, you will receive an External Review Request form. Submit the form and the requested documentation to us within four months at the address appearing on the form.

You may also be eligible for an expedited external review if your treating physician believes that a delay in decision making might seriously jeopardize (put at risk) the life or health of the member or jeopardizes the member's ability to regain maximum function. Expedited External Review forms are submitted by your treating physician.

For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at

1-866-444-EBSA (1-866-444-3272). For questions about the external review forms or process, please call Member Services at the phone number shown on your ID card, or visit our website at: **www.aetna.com/products/ext_review.html.**

Your request for an External Review will not affect your rights to any other benefits under the plan or your right to representation. Your request will not affect the process for selecting the External Review Organization or the impartiality of the physician reviewer.

STANDARD APPEAL PROCESS FOR NON-URGENT SERVICES AND DENIED CLAIMS

Formal Appeal (Level One)

Your request: You may obtain Formal Appeal 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 formal appeal within 2 years of the date we first deny the requested service or claim by calling, writing, or faxing your request to:

Name: Aetna Life Insurance Company
Title: Customer Resolution Team
Address: P.O. Box 14002, Lexington, KY 40512
Phone: 1-800-545-2211
Fax: 859-425-3379

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

If we deny your request for a Pre-Service Claim — within 30 calendar days. A Pre-Service Claims is a claim for a benefit that requires approval of the benefit in advance of obtaining medical care. **You have 4 months to appeal to Level Two.**

If we deny your request for a Concurrent Care Claim Extension— within 30 calendar days. A Concurrent Care Claim Extension is a request to extend or a decision to reduce a previously approved course of treatment. **You have 4 months to appeal to Level Two.**

If we deny your request for a Post-Service Claim — within 60 calendar days. A Post-Service Claim is any claim for a benefit that is not a pre-service claim. **You have 4 months to appeal to Level Two.**

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

External, Independent Review (Level Two)

Once you have completed the appeal process with Aetna, you may request an external review.

External reviews are conducted by independent physicians with expertise in the medical service or supply at issue. Once a review is complete, Aetna accepts the decision of the external reviewer.

Once you are eligible, you will receive an External Review Request form. Submit the form and the requested documentation to us within four months at the address appearing on the form.

You may also be eligible for an expedited external review if your treating physician believes that a delay in decision making might seriously jeopardize (put at risk) the life or health of the member or jeopardizes the member's ability to regain maximum function. Expedited External Review forms are submitted by your treating physician.

For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at

1-866-444-EBSA (1-866-444-3272). For questions about the external review forms or process, please call Member Services at the phone number shown on your ID card, or visit our website at: **www.aetna.com/products/ext_review.html.**

Your request for an External Review will not affect your rights to any other benefits under the plan or your right to representation. Your request will not affect the process for selecting the External Review Organization or the impartiality of the physician reviewer.

II. The Role of the Director of Insurance.

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

The Appeal process requires the Director to:

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

III. Obtaining Medical Records.

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

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

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

IV. Documentation for an Appeal.

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

V. Receipt of Documents.

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

VI. Record Retention.

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

VII. Fees and Costs.

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

Submit completed forms to:

For Expedited & Standard Level 1
Aetna Health Inc./
Corporate Health Insurance Company
Customer Resolution Team
P.O. Box 14002
Lexington, KY 40512
Expedited Appeal Fax: 860-754-5321
Standard Appeal Fax: 859-425-3379

For Expedited & Standard External Independent Review (Level 2)
Priscilla Bugari, R.N.
Director, Aetna National External Review Unit
11675 Great Oaks Way
Alpharetta, GA 30022
Phone: 1-877-848-5855
Fax: 860-975-1526

HEALTHCARE APPEAL REQUEST FORM

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

Insured Member's Name_____ Member ID#_____

Name of representative pursuing appeal, if different from above_____

Mailing Address_____ Phone #_____

City_____ State _____ Zip Code_____

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

Name of Insurer that denied the claim/service:_____

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

What decision are you appealing?

_____

_____

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

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

_____

_____

_____ *(Attach additional sheets of paper, if needed.)*

If you have questions about the appeals process or need help to prepare your appeal, you may call the Department of Insurance Consumer Assistance number 602-364-2499 or 602-364-2496 or 1-800-325-2548 (inside Arizona but outside the Phoenix area),

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**

Submit completed forms to:
Aetna Health Inc./Corporate Health Insurance Company
Customer Resolution Team
P.O. Box 14002
Lexington, KY 40512
Fax: 860-754-5321

PROVIDER CERTIFICATION FORM FOR EXPEDITED MEDICAL REVIEWS

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

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

PROVIDER INFORMATION

Treating Physician/Provider_____

Phone #_____ FAX #_____

Address_____

City_____ State_____ Zip Code_____

PATIENT INFORMATION

Patient's Name_____ Member ID #_____

Phone #_____

Address_____

City_____ State_____ Zip Code_____

INSURER INFORMATION

Insurer Name_____

Phone #_____ FAX #_____

Address_____

City_____ State_____ Zip Code_____

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

What service denial is the patient appealing?

_____

_____

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

_____

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

If you have questions about the appeals process or need help regarding this certification, you may call the Department of Insurance Consumer Assistance number 602-364-2499 or 602-364-2496 or 1-800-325-2548 (inside Arizona but outside the Phoenix area). You may also call the 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 Level One and Level Two appeal processes (about 30 days) is likely to cause a significant negative change in the patient's medical condition at issue.

Provider's Signature_____ **Date**_____

WHERE CAN I FIND TIPS AND TOOLS FOR **STAYING HEALTHY**?

Aetna InteliHealth® is your trusted, one-stop source for online health and wellness information. This helpful website is filled with valuable tips and tools, all in an easy-to-read format.

You'll find all kinds of great information on InteliHealth.com, including: health news; a medical dictionary; a drug resource center; fitness, nutrition and weight management information; daily and weekly health-related e-mails; and much more. Check it out at **www.intelihealth.com**.

I ALWAYS NEED SOME INCENTIVE TO GET IN SHAPE. WHAT CAN YOU OFFER ME?

A fit body is a healthier body. Aetna can help you stay in shape. Access the Aetna Fitness℠ discount program and you'll receive preferred rates on gym memberships as well as discounts on at-home weight loss programs, home fitness options, and one-on-one health coaching services through GlobalFit™.

So get ready to start exercising — and feeling good.

With these savings, it's a great time to join the Fitness Program from Aetna.

Explore a smarter health plan. Visit us at **www.aetna.com**.

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Aetna has been in business for more than 150 years.

In 2010, for the third year in a row, Aetna was named the most admired health care insurance company by *Fortune* magazine.*

* *Fortune* magazine, March 22, 2010, March 16, 2009, and March 17, 2008

Aetna®

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