Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

aetna℠

Here’s to your health

Our plan offers you what you need to stay healthy.
Learn more.

For more information about the plan, please call 1-866-234-3129 (TDD: 711); from 8 a.m. to 6 p.m., Monday through Friday

Welcome to the Aetna Medicare Advantage[SM] Plan. New for 2013, Aetna will be offering additional Medicare Advantage plans to New Jersey State Health Benefits Program and School Employees' Health Benefits Program retirees who are eligible for Medicare. You have four Aetna Medicare Advantage Plans from which to choose:

- Aetna Medicare Advantage PPO ESA 10
- Aetna Medicare Advantage PPO ESA 15
- Aetna Medicare Advantage HMO 10* Open Access
- Aetna Medicare Advantage HMO 1525* Open Access

This booklet is designed to answer questions and help you understand the details of this plan. Our plans offer benefits beyond Original Medicare, including preventive care, wellness programs, and coverage for medical emergencies when traveling. We also offer access to our National Medical Excellence Program® which includes a select network of doctors and facilities. No matter what your health care needs, we can supply you with the resources you need to succeed.

Please review this information package for plan details. If you decide to choose an Aetna Medicare Advantage plan, follow the instructions below.

Our goal is to give you what you need to be as healthy as you can possibly be.

GETTING STARTED

To make an election you must submit a Retired Change of Status Application. This application is for enrolled retirees who are changing plans or coverage levels. To obtain this form you may contact the Division of Pensions and Benefits Office of Client Services at (609) 292-7524 or you can access the form by visiting the following website: http://www.state.nj.us/treasury/pensions/epbam/exhibits/pdf/hr0809.pdf

*Aetna Medicare Advantage HMO is available only in select service areas. Call Aetna to determine if you live in a select service area.

58.32.600.1-SONJ A (10/12)

The benefit information provided herein is a brief summary, not a comprehensive description of benefits. For more information contact the plan. Aetna Medicare is a Medicare Advantage organization with a Medicare contract. Benefits, premium and/or co-payments/co-insurance may change on January 1 of each year.

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna). Not all health 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. You must be entitled to Medicare Part A and continue to pay your Part B premium and Part A, if applicable.

Why

Aetna Medicare Advantage Preferred Provider Organization (PPO) with an Extended Service Area (ESA)?

The Aetna Medicare[SM] (PPO) plan with an Extended Service Area (ESA) offers services and programs beyond Original Medicare and includes special programs only available to Aetna members. And, unlike a traditional PPO, you can use in-network or out-of-network providers, at the in-network cost sharing amount. This gives you added flexibility when it comes to your care.

58.02.303.1-SONJ (10/12)

Aetna Medicare Plan (PPO) with an Extended Service Area (ESA)

Plan details:

You can use providers who are in or out of the plan's nationwide network. An out-of-network provider must be eligible to receive Medicare payment and willing to accept the PPO ESA plan.

What's special:

- Our Care Management program is designed to help you manage health conditions such as hypertension.
- Freedom to use providers in and out of network as long as they are eligible for Medicare payment and agree to accept your PPO plan.
- Selecting a primary care physician (PCP) is not required, but we do encourage you to select one. A PCP is often the doctor who has a complete picture of your health. If you do not have a PCP, you may find one within our network. If your PCP is not in our network, you can encourage him/her to join Aetna.
- Access to the National Medical Excellence Program,® a select network of respected doctors and facilities designed to help those with a complex illness or injury receive the most appropriate care.
- Preventive benefits beyond Original Medicare at no additional cost.

What you should know:

- You must be enrolled in Medicare Part A and/or B and continue to pay your Part B premium and Part A premium, if applicable.
- Guaranteed acceptance as long as you meet eligibility requirements.
- You must live in the plan service area offered by your former employer.
- You'll enjoy limits to your out-of-pocket plan costs.
- If you use a provider that does not participate in the plan's network, the provider must be licensed, eligible to receive Medicare payment and willing to accept the plan.
- For complete information, please refer to your plan documents.

What benefits do I get as a member?

With the Aetna Medicare Plan (PPO) with an Extended Service Area (ESA), you may have access to many or more of the same great benefits that you may have now. Check it out.

Benefits at-a-glance[1]	Aetna Medicare PPO Plan with an Extended Service Area
No network restrictions. Freedom to use any licensed provider that is eligible for Medicare and willing to accept the PPO ESA plan	✓*
No referrals needed for specialists	✓
Includes all Medicare Parts A and B medical benefits, plus additional benefits not covered by Original Medicare	✓
Limitations on your out-of-pocket costs	✓
Coverage for unlimited inpatient hospital days	✓
Preventive benefits beyond Original Medicare at no additional cost	✓
Healthy lifestyle coaching at no extra cost	✓
Online Personal Health Record that helps you make informed health care decisions, at no extra cost	✓
Special program designed to help you manage your health conditions	✓
Coverage for emergency or urgently needed medical treatments worldwide	✓
Guaranteed acceptance as long as you meet eligibility requirements	✓
No waiting period for pre-existing medical conditions	✓
Access to Aetna Navigator® claim searches	✓
Access to our 24-hour Informed Health® Line	✓
Aetna Extras℠ at no extra cost: discounts on health-related products and services	✓

[1] While only your doctor can diagnose, prescribe or give medical advice, the Informed Health Line nurses can provide information on more than 5,000 topics. Contact your doctor first with any questions or concerns regarding your health care needs. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professionals.

*You will pay the low in-network cost share amount whether you use providers in- or out-of-network. If you use an out-of-network provider, they must accept your PPO ESA plan and be eligible to receive Medicare payment.

The benefit information provided herein is a brief summary, not a comprehensive description of benefits. For more information contact the plan. A Medicare Advantage organization with a Medicare contract. Health insurance plans are offered by Aetna Life Insurance Company. Plans contain exclusions and limitations. You must be entitled to Medicare Part A and Part B. You must continue to pay your Part B premium and Part A, if applicable unless you are enrolled in an Aetna Medicare Advantage Part B only plan and reside in the service area of the plan.

Benefits, limitations, service areas and premiums are subject to change on January 1 of each year.

Member precertification, or prior approval of coverage, is recommended for certain services. Providers must be licensed, eligible to receive payment under the federal Medicare program and willing to accept your PPO plan.

This material is for informational purposes only. Not all health 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.

Aetna does not provide care or guarantee access to health services. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Discount programs provide access to discounted prices and are not insured benefits.

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

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State of New Jersey
Aetna Medicare SM Plan (PPO)
Aetna ESA 10

Benefits, Value Added Services and Premiums are effective January 1, 2013 through December 31, 2013

National

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	Network Providers	Out-of-Network Providers
Deductible (per calendar year)	$0 Deductible	$0 Deductible

Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Deductible is NOT applicable to Hearing Aid Reimbursement, Vision Reimbursement and Medicare prescription drug coverage that may be available on your plan.

Member Coinsurance	N/A	N/A
Applies to all expenses unless otherwise stated.		
Annual Maximum Out-of-Pocket Amount (includes deductible)	$1,000	N/A
Combined Annual Maximum Out-of-Pocket Amount (Plan Level / includes deductible)	N/A	$1,000

Annual Maximum Out-of-pocket Limit amount applies to all medical expenses EXCEPT Hearing Aid Reimbursement, Vision Reimbursement and Medicare prescription drug coverage that may be available on your plan.

Primary Care Physician Selection	Optional	Not Applicable

Certification Requirements
There is not a requirement for member pre-certification. If a member fails to obtain pre-certification they will not be denied services or will any penalty amount be applied. However, pre-certificaiton is requested on certain services including inpatient hospital care, inpatient mental health and substance abuse, skilled nursing facility, home health care and some durable medical equipment.

Referral Requirement	None	None
PREVENTIVE CARE		
Routine Physicals (Yearly Wellness Exams) /	Covered 100%	Covered 100%
One annual exam. Pneumococcal, Flu, Hepatitis B covered 100%		

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Routine GYN Care (Cervical and Vaginal Cancer Screenings) Exams **One routine GYN visit and pap smear every 12 months**	Covered 100%	Covered 100%
Routine Mammograms (Breast Cancer Screening) One baseline mammogram for members 35-39; and one annual mammogram for members age 40 and over	Covered 100%	Covered 100%
Routine Prostate Cancer Screening Exam For covered males age 50 and over every 12 months	Covered 100%	Covered 100%
Routine Colorectal Cancer Screening For all members age 50 and over.	Covered 100%	Covered 100%
Routine Bone Mass	Covered 100%	Covered 100%
Additional Medicare Preventive Services* **	Covered 100%	Covered 100%
Routine Eye Exams One(1) annual exam	Covered 100%	Covered 100%
Routine Hearing Exams One(1) annual exam	Covered 100%	Covered 100%
PHYSICIAN SERVICES		
Primary Care Physician Visits	$10 copay	$10 copay
Primary Care Physician Visits (after hours) Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.	$10 copay	$10 copay
Physician Specialist Visits	$10 copay	$10 copay

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Office Visits for Surgery	$10 copay	$10 copay
Allergy Testing/Treatment	$10 copay	$10 copay
DIAGNOSTIC PROCEDURES		
Outpatient Diagnostic Laboratory and X-Ray	$10 copay	$10 copay
EMERGENCY MEDICAL CARE		
Urgently Needed Care	$10 copay	$10 copay
Emergency Room; Worldwide (waived if admitted)	$25 copay	$25 copay
Ambulance Services	Covered 100%	Covered 100%
HOSPITAL CARE		
Inpatient Hospital Care	Covered 100%	Covered 100%
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Hospital Expenses (including surgery)	Covered 100%	Covered 100%
The member cost sharing applies to covered benefits incurred during a member's outpatient visit.		
MENTAL HEALTH SERVICES		
Inpatient Mental Health Care	Covered 100%	Covered 100%
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Mental Health Care	$10 copay	$10 copay
The member cost sharing applies to covered benefits incurred during a member's outpatient visit.		
ALCOHOL/DRUG ABUSE SERVICES		
Inpatient Substance Abuse (Detox and Rehab)	Covered 100%	Covered 100%
The member cost sharing applies to covered benefits incurred during a member's inpatient stay		
Outpatient Substance Abuse (Detox and Rehab)	Covered 100%	Covered 100%
The member cost sharing applies to covered benefits incurred during a member's outpatient visit.		
OTHER SERVICES		

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Skilled Nursing Facility Limited to 120 days per Medicare benefit period. The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	Covered 100%	Covered 100%
Home Health Agency Care	Covered 100%	Covered 100%
Hospice Care	Covered by Medicare at a Medicare certified hospice	Covered by Medicare at a Medicare certified hospice
Outpatient Rehabilitation Services Includes speech, physical, and occupational therapy.	$10 copay	$10 copay
Chiropractic Services For manipulation of the spine to the extent covered by Medicare	$15 copay	$15 copay
Durable Medical Equipment/ Prosthetic Devices	Covered 100%	Covered 100%
Podiatry Services **Limited to Medicare covered benefits only**	$10 copay	$10 copay
Diabetic Supplies	Covered 100%	Covered 100%
Outpatient Complex Radiology	$10 copay	$10 copay
Outpatient Dialysis Treatments	$10 copay	$10 copay
Medicare Part B Prescription Drugs	Covered 100%	Covered 100%
Vision Eyewear Allowance	Lens Discounts	Same as preferred care.
Hearing Aid Reimbursement	Discounts where available	Same as Preferred tier
Coaching One phone call per week	Included	Not covered

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

*** Additional Medicare Preventive Services include ultrasound screening for abdominal aortic aneurysm (AAA), cardiovascular disease screening, diabetes screening tests, diabetes self-management training (DSMT), medical nutrition therapy, glaucoma screening, smoking & tobacco use cessation counseling, HIV screening and annual wellness visit.

Benefits, limitations, service areas and premiums are subject to change on January 1 of each year.

Members must be entitled to Medicare Part A and continue to pay the Part B premium and Part A, if applicable.

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In case of emergency, members should call 911 or the local emergency hotline, or go directly to an emergency care facility.

The following is a partial listing of exclusions and limitations under the Aetna Medicare SM Plan

- Services that are not medically necessary or covered under the Original Medicare Program;
- Plastic or cosmetic surgery unless medically necessary;
- Custodial care;
- Experimental procedures or treatments beyond Original Medicare limits;
- Routine foot care that is not medically necessary
- Outpatient Prescription Drugs except those covered under Original Medicare Part B.

Precertification, or prior approval of coverage is requested for certain services. Providers must be licensed and eligible to receive payment under the federal Medicare program.

Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Information is believed to be accurate as of the production date; however, it is subject to change. In the event of a conflict or inconsistency between this material and plan documents, the terms of the plan document shall govern.

Discount programs provide access to discounted prices and are not insured benefits. The member is responsible for the full cost of the discounted services.

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Health Benefits and Health Insurance plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna). A Medicare Advantage organization with a Medicare contract. A Medicare approved Part D sponsor.

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Hours of operation: Monday through Friday, 8am till 6pm. Este documento podría estar disponsible en diferentes formatos o idiomas. Para ayuda, por favor llame a Servicios al Miembro al 1-866-234-3129 (TTY/TDD: 711). Las llamadas a este número son gratuitas.
Horario de atención: Lunes al Viernes, de 8 a.m. a 6 p.m.

For more information about Aetna plans, refer to www.aetna.com.
2012 Aetna Medicare

*****This is the end of this plan benefit summary*****

Benefits, Value Added Services and Premiums are effective January 1, 2013 through December 31, 2013

National

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	Network Providers	Out-of-Network Providers
Deductible (per calendar year)	$0 Deductible	$0 Deductible
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Deductible is NOT applicable to Hearing Aid Reimbursement, Vision Reimbursement and Medicare prescription drug coverage that may be available on your plan.		
Member Coinsurance	N/A	N/A
Applies to all expenses unless otherwise stated.		
Annual Maximum Out-of-Pocket Amount (includes deductible)	$1,000	N/A
Combined Annual Maximum Out-of-Pocket Amount (Plan Level / includes deductible)	N/A	$1,000
Annual Maximum Out-of-pocket Limit amount applies to all medical expenses EXCEPT Hearing Aid Reimbursement, Vision Reimbursement and Medicare prescription drug coverage that may be available on your plan.		
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements		
There is not a requirement for member pre-certification. If a member fails to obtain pre-certification they will not be denied services or will any penalty amount be applied. However, pre-certificaiton is requested on certain services including inpatient hospital care, inpatient mental health and substance abuse, skilled nursing facility, home health care and some durable medical equipment.		
Referral Requirement	None	None
PREVENTIVE CARE		
Routine Physicals (Yearly Wellness Exams) /	Covered 100%	Covered 100%
One annual exam. Pneumococcal, Flu, Hepatitis B covered 100%		

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Routine GYN Care (Cervical and Vaginal Cancer Screenings) Exams **One routine GYN visit and pap smear every 12 months**	Covered 100%	Covered 100%
Routine Mammograms (Breast Cancer Screening) One baseline mammogram for members 35-39; and one annual mammogram for members age 40 and over	Covered 100%	Covered 100%
Routine Prostate Cancer Screening Exam For covered males age 50 and over every 12 months	Covered 100%	Covered 100%
Routine Colorectal Cancer Screening For all members age 50 and over.	Covered 100%	Covered 100%
Routine Bone Mass	Covered 100%	Covered 100%
Additional Medicare Preventive Services* **	Covered 100%	Covered 100%
Routine Eye Exams One(1) annual exam	Covered 100%	Covered 100%
Routine Hearing Exams One(1) annual exam	Covered 100%	Covered 100%
PHYSICIAN SERVICES		
Primary Care Physician Visits	$15 copay	$15 copay
Primary Care Physician Visits (after hours) Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.	$15 copay	$15 copay
Physician Specialist Visits	$15 copay	$15 copay

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Office Visits for Surgery	$15 copay	$15 copay
Allergy Testing/Treatment	$15 copay	$15 copay
DIAGNOSTIC PROCEDURES		
Outpatient Diagnostic Laboratory and X-Ray	$15 copay	$15 copay
EMERGENCY MEDICAL CARE		
Urgently Needed Care	$15 copay	$15 copay
Emergency Room; Worldwide (waived if admitted)	$50 copay	$50 copay
Ambulance Services	Covered 100%	Covered 100%
HOSPITAL CARE		
Inpatient Hospital Care	Covered 100%	Covered 100%
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Hospital Expenses (including surgery)	Covered 100%	Covered 100%
The member cost sharing applies to covered benefits incurred during a member's outpatient visit.		
MENTAL HEALTH SERVICES		
Inpatient Mental Health Care	Covered 100%	Covered 100%
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Mental Health Care	$15 copay	$15 copay
The member cost sharing applies to covered benefits incurred during a member's outpatient visit.		
ALCOHOL/DRUG ABUSE SERVICES		
Inpatient Substance Abuse (Detox and Rehab)	Covered 100%	Covered 100%
The member cost sharing applies to covered benefits incurred during a member's inpatient stay		
Outpatient Substance Abuse (Detox and Rehab)	Covered 100%	Covered 100%
The member cost sharing applies to covered benefits incurred during a member's outpatient visit.		
OTHER SERVICES		

PLAN DESIGN AND BENEFITS
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Skilled Nursing Facility Limited to 120 days per Medicare benefit period. The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	Covered 100%	Covered 100%
Home Health Agency Care	Covered 100%	Covered 100%
Hospice Care	Covered by Medicare at a Medicare certified hospice	Covered by Medicare at a Medicare certified hospice
Outpatient Rehabilitation Services Includes speech, physical, and occupational therapy.	$15 copay	$15 copay
Chiropractic Services For manipulation of the spine to the extent covered by Medicare	$15 copay	$15 copay
Durable Medical Equipment/ Prosthetic Devices	Covered 100%	Covered 100%
Podiatry Services **Limited to Medicare covered benefits only**	$15 copay	$15 copay
Diabetic Supplies	Covered 100%	Covered 100%
Outpatient Complex Radiology	$15copay	$15copay
Outpatient Dialysis Treatments	$15 copay	$15 copay
Medicare Part B Prescription Drugs	Covered 100%	Covered 100%
Vision Eyewear Allowance	Lens Discounts	Same as preferred care.
Hearing Aid Reimbursement	Discounts where available	Same as Preferred tier
Coaching One phone call per week	Included	Not covered

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

*** Additional Medicare Preventive Services include ultrasound screening for abdominal aortic aneurysm (AAA), cardiovascular disease screening, diabetes screening tests, diabetes self-management training (DSMT), medical nutrition therapy, glaucoma screening, smoking & tobacco use cessation counseling, HIV screening and annual wellness visit.

Benefits, limitations, service areas and premiums are subject to change on January 1 of each year.

Members must be entitled to Medicare Part A and continue to pay the Part B premium and Part A, if applicable.

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In case of emergency, members should call 911 or the local emergency hotline, or go directly to an emergency care facility.

The following is a partial listing of exclusions and limitations under the Aetna Medicare SM Plan

- Services that are not medically necessary or covered under the Original Medicare Program;
- Plastic or cosmetic surgery unless medically necessary;
- Custodial care;
- Experimental procedures or treatments beyond Original Medicare limits;
- Routine foot care that is not medically necessary
- Outpatient Prescription Drugs except those covered under Original Medicare Part B.

Precertification, or prior approval of coverage is requested for certain services. Providers must be licensed and eligible to receive payment under the federal Medicare program.

Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Information is believed to be accurate as of the production date; however, it is subject to change. In the event of a conflict or inconsistency between this material and plan documents, the terms of the plan document shall govern.

Discount programs provide access to discounted prices and are not insured benefits. The member is responsible for the full cost of the discounted services.

Benefits, Value Added Services and Premiums are effective January 1, 2013 through December 31, 2013

National

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

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2012 Aetna Medicare

*****This is the end of this plan benefit summary*****

Why

Aetna Medicare Advantage Health Maintenance Organization Plan (HMO) Open Access?

The Aetna Medicare[SM] Plan (HMO) Open Access includes coverage for Medicare Parts A and B benefits, and it goes beyond those benefits to offer you additional benefits not covered under Original Medicare. Our HMO offers you an affordable way to help you manage your health care costs.

Aetna Medicare Plan (HMO) Open Access

Plan details:

You typically pay a flat fee, or copay, for most covered expenses. You are required to select a Primary Care Physician (PCP) from the plan's network. With the Aetna Medicare Plan (HMO) Open Access, you may access care from participating providers without a PCP referral. If you seek care from a provider who does not accept the Aetna Medicare Plan, services will not be covered, except in an emergency or urgent care situation, or for out-of-area kidney dialysis. For some services, you may pay a percentage of the expense (coinsurance).

What's special:

- Our Care Management program is designed to help you manage health conditions such as hypertension.
- You have access to the large Aetna Medicare HMO network of doctors, hospitals and other health care providers. (To find participating network providers, go to www.aetnaretireeplans.com and click on Find a Doctor.)
- Access to the National Medical Excellence Program,® a select network of respected doctors and facilities designed to help those with a complex illness or injury receive the most appropriate care.
- You have medical coverage whenever you travel to another Aetna Medicare Plan service area with Aetna's U.S. Travel Advantage Program; however, you must enroll by calling Aetna Medicare before you travel.
- Preventive benefits not covered under Medicare at no additional cost.

What you should know:

- You must be enrolled in Medicare Part A and/or B and continue to pay your Part B premium and Part A premium, if applicable.
- Guaranteed acceptance as long as you meet eligibility requirements.
- You must live in the plan service area offered by your former employer.
- You may directly access participating providers without a PCP referral, subject to the terms and conditions of the plan and cost-sharing requirements.
- You'll enjoy predictable out-of-pocket plan limits.
- For complete information, please refer to your plan documents.

What benefits do I get as a member?

With the Aetna Medicare Plan (HMO) Open Access, you must choose your PCP and see providers in our Aetna Medicare HMO network. You can change your PCP at any time.

Benefits at-a-glance[1]	Aetna Medicare Plan HMO
Includes all Medicare Parts A and B medical benefits, plus additional benefits not covered by Original Medicare at no additional cost	✓
Limitations on your out-of-pocket costs for most plans	✓
Coverage for unlimited inpatient hospital days	✓
Discounts on vision care, hearing aids, vitamins and other health-related products	✓
Healthy lifestyle coaching at no extra cost	✓
Online Personal Health Record that helps you make informed health care decisions, at no extra cost	✓
Special program designed to help you manage your health conditions	✓
Emergency or urgently needed medical treatments worldwide	✓
Guaranteed acceptance as long as you meet eligibility requirements	✓
No waiting period for pre-existing medical conditions	✓
Access to Aetna Navigator® claim searches	✓
Access to our 24-hour Informed Health® Line	✓
Aetna Extras℠ at no extra cost: discounts on health-related products and services	✓

[1] While only your doctor can diagnose, prescribe or give medical advice, the Informed Health Line nurses can provide information on more than 5,000 topics. Contact your doctor first with any questions or concerns regarding your health care needs. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professionals.

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Benefits, limitations, service areas and premiums are subject to change on January 1 of each year. This material is for informational purposes only. Not all health 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.

Aetna does not provide care or guarantee access to health services. If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group. You must use network providers except for emergent care or out-of-area urgent care/renal dialysis services. Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Discount programs provide access to discounted prices and are NOT insured benefits.

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Puede estar disponible la traducción de este material en otro idioma. Para asistencia, por favor llame a Servicio al Cliente al teléfono indicado al inicio de este documento bajo “Contáctenos.”

Benefits, Value Added Services and Premiums are effective January 1, 2013 through December 31, 2013

Arizona, Connecticut, Colorado, Delaware, District of Columbia, Florida, Georgia, Illinois, Massachusetts, Maryland, Maine, North Carolina, New Jersey, Nevada, New York, Ohio, Oklahoma, Pennsylvania, Tennessee, Texas, Virginia

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA HEALTH INC

PLAN FEATURES	Network Providers
Deductible (per calendar year)	$0 Deductible
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Deductible is NOT applicable to Hearing Aid Reimbursement, Vision Reimbursement, Dental and Medicare prescription drug coverage that may be available on your plan.	
Annual Maximum Out-of-pocket amount (includes Deductible)	$2,500
Annual Maximum Out-of-pocket Limit applies to all medical expenses EXCEPT Hearing Aid Reimbursement, Vision Reimbursement, Dental and Medicare prescription drug coverage that may be available on your plan.	
Primary Care Physician Selection	Recommended
Referral Requirements	No referral required when using In-network providers.
ROUTINE PREVENTIVE CARE	
Routine Physical (Yearly Wellness Exams) /Immunizations (One exam every 12 months /Pneumonia, Flu, Hepatitis B)	Covered 100%
Routine GYN Care (Cervical and Vaginal Cancer Screenings)	Covered 100%
Includes related lab fees for covered females age 18 and older. Direct Access to participating providers. One routine GYN visit and pap smear every 12 months.	
Routine Mammogram (Breast Cancer Screer	Covered 100%
One baseline mammogram for members 35-39; and one annual mammogram for members age 40 and over	
Routine Prostate Cancer Screening Exam For males age 50 and over every 12 months	Covered 100%
Routine Colorectal Cancer Screening For all members 50 and over every 12 months	Covered 100%
Routine Bone Mass Measurement One exam every 12 months	Covered 100%

Benefits, Value Added Services and Premiums are effective January 1, 2013 through December 31, 2013

Arizona, Connecticut, Colorado, Delaware, District of Columbia, Florida, Georgia, Illinois, Massachusetts, Maryland, Maine, North Carolina, New Jersey, Nevada, New York, Ohio, Oklahoma, Pennsylvania, Tennessee, Texas, Virginia

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA HEALTH INC

Additional Medicare Preventive Services* **	Covered 100%
Routine Eye Exam	Covered 100%
Direct access to participating providers. One annual exam.	
Routine Hearing Screening	Covered 100%
One exam every 12 months	
PHYSICIAN SERVICES	**Network Providers**
Primary Care Physician Visits	
(Office hours)	$10 copay
(After Office Hours)	$15 copay
Physician Specialist Visits	$10 copay
Podiatry Services	$10 copay
Limited to Medicare covered benefits only	
Allergy Testing/Treatment	$10 copay
For initial testing by a specialist; PCP copay for routine injections at PCP office with or without physician encounter	
DIAGNOSTIC PROCEDURES	**Network Providers**
Outpatient Diagnostic Laboratory and X-Ray	Covered 100%
EMERGENCY MEDICAL CARE	**Network Providers**
Urgently Needed Care	$35 copay
Emergency Room; Worldwide (waived if admitted)	$35 copay
Ambulance Services	Covered 100%
HOSPITAL CARE	**Network Providers**
Inpatient Hospital Care	Covered 100%
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Outpatient Surgery	Covered 100%
The member cost sharing applies to covered benefits incurred during a member's outpatient visit.	
MENTAL HEALTH SERVICES	**Network Providers**
Inpatient Mental Health Care	Covered 100%
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	

Outpatient Mental Health Care	$10 copay
The member cost sharing applies to covered benefits incurred during a member's outpatient visit.	
ALCOHOL/DRUG ABUSE SERVICES	**Network Providers**
Inpatient Substance Abuse (Detox and Rehab)	Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Outpatient Substance Abuse (Detox and Rehab)	Covered 100%
The member cost sharing applies to covered benefits incurred during a member's outpatient v	
OTHER SERVICES	**Network Providers**
Skilled Nursing Facility	Covered 100%
(120 days per Medicare benefit period; prior authorization from HMO required) The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Home Health Agency Care	Covered 100%
Hospice Care	Covered by Medicare at Medicare certified Hospice.
Outpatient Rehabilitation Services (speech, physical, cardiac and occupational)	$10 copay
Chiropractic Services	$10 copay
For manual manipulation of the spine to the extent covered by Medicare	
Durable Medical Equipment/Prosthetic Devices	Covered 100%
Diabetic Supplies	No copay for strips, lancets, and glucometer.
Outpatient Complex Radiology:	
CAT/ PET/ MRI	Covered 100%
Radiation Therapy	$10 copay
Outpatient Dialysis	$10 copay
Medicare Part B Prescription Drugs	Covered 100%
Dental *	Discounts where available

Benefits, Value Added Services and Premiums are effective January 1, 2013 through December 31, 2013

Arizona, Connecticut, Colorado, Delaware, District of Columbia, Florida, Georgia, Illinois, Massachusetts, Maryland, Maine, North Carolina, New Jersey, Nevada, New York, Ohio, Oklahoma, Pennsylvania, Tennessee, Texas, Virginia

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA HEALTH INC

Vision Eyewear Allowance	Lens Discounts
Hearing Aid Reimbursement	Discounts where available
Coaching One phone call per week	Included

* Dental Benefits are not available in all service areas. Refer to your plan documents for a complete description of the benefits or discounts available.

*** Additional Medicare Preventive Services include ultrasound screening for abdominal aortic aneurysm (AAA), cardiovascular disease screening, diabetes screening tests, diabetes self-management training (DSMT), medical nutrition therapy, glaucoma screening, smoking & tobacco use cessation counseling, HIV screening and annual wellness visit.

Benefits, limitations, service areas and premiums are subject to change on January 1 of
Members must be entitled to Medicare Part A and continue to pay the Part B premium and Part A, if applicable.
This material is for informational purposes only. Not all health 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. Providers are independent contractors and are not agents of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. Aetna does not provide care or guarantee access to health services.

In case of emergency, members should call 911 or the local emergency hotline, or go directly to an emergency care facility.

The following is a partial listing of exclusions and limitations under the Aetna Medicare SM
• All applicable services not referred by the network primary care doctor, except for services received as a result of an emergency or urgent situation;
• Services that are not medically necessary or covered under the Original Medicare Program;
• Plastic or cosmetic surgery unless medically necessary;
• Custodial care;
• Experimental procedures or treatments beyond Original Medicare limits;
• Routine foot care that is not medically necessary
• Outpatient Prescription Drugs except those covered under Original Medicare Part B.

Benefits, Value Added Services and Premiums are effective January 1, 2013 through December 31, 2013

Arizona, Connecticut, Colorado, Delaware, District of Columbia, Florida, Georgia, Illinois, Massachusetts, Maryland, Maine, North Carolina, New Jersey, Nevada, New York, Ohio, Oklahoma, Pennsylvania, Tennessee, Texas, Virginia

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA HEALTH INC

Members must use network providers except for emergent care or out-of-area urgent care/renal dialysis. If care is received from out-of-network providers neither Medicare nor Aetna Medicare[SM] Plan (HMO) will be responsible for the costs. If the primary physician is part of an integrated delivery system or physician group, the primary care physician will generally refer members to specialists and hospitals that are affiliated with the delivery system or physician group.

Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Information is believed to be accurate as of the production date; however, it is subject to change. In the event of a conflict or inconsistency between this material and plan documents, the terms of the plan document shall govern.

Discount programs provide access to discounted prices and are not insured benefits. The member is responsible for the full cost of the discounted services.
Health benefits and health insurance plans contain exclusions and limitations.

Health Benefits and Health Insurance plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna). A Medicare Advantage organization with a Medicare contract. A Medicare approved Part D sponsor.

This document may be available in a different format or language. For assistance, please call Member Services at 1-866-234-3129 (TTY/TDD: 711). Calls to this number are free. Hours of operation: Monday through Friday, 8am till 6pm. Este documento podría estar disponsible en diferentes formatos o idiomas. Para ayuda, por favor llame a Servicios al Miembro al 1-866-234-3129 (TTY/TDD: 711). Las llamadas a este número son gratuitas. Horario de atención: Lunes al Viernes, de 8 a.m. a 6 p.m.

For more information about Aetna plans, refer to www.aetna.com.

2012 Aetna Medicare

*****This is the end of this plan benefit summary*****

State of New Jersey
Aetna Medicare SM Plan (HMO)
MA HMO 1525 Plan

Benefits, Value Added Services and Premiums are effective January 1, 2013 through December 31, 2013

Arizona, Connecticut, Colorado, Delaware, District of Columbia, Florida, Georgia, Illinois, Massachusetts, Maryland, Maine, North Carolina, New Jersey, Nevada, New York, Ohio, Oklahoma, Pennsylvania, Tennessee, Texas, Virginia

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA HEALTH INC

PLAN FEATURES	Network Providers
Deductible (per calendar year) Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Deductible is NOT applicable to Hearing Aid Reimbursement, Vision Reimbursement, Dental and Medicare prescription drug coverage that may be available on your plan.	$0 Deductible
Annual Maximum Out-of-pocket amount (includes Deductible) Annual Maximum Out-of-pocket Limit applies to all medical expenses EXCEPT Hearing Aid Reimbursement, Vision Reimbursement, Dental and Medicare prescription drug coverage that may be available on your plan.	$2,500
Primary Care Physician Selection	Recommended
Referral Requirements	No referral required when using In-network providers.
ROUTINE PREVENTIVE CARE	
Routine Physical (Yearly Wellness Exams) /Immunizations (One exam every 12 months /Pneumonia, Flu, Hepatitis B)	Covered 100%
Routine GYN Care (Cervical and Vaginal Cancer Screenings) Includes related lab fees for covered females age 18 and older. Direct Access to participating providers. One routine GYN visit and pap smear every 12 months.	Covered 100%
Routine Mammogram (Breast Cancer Screer One baseline mammogram for members 35-39; and one annual mammogram for members age 40 and over	Covered 100%
Routine Prostate Cancer Screening Exam For males age 50 and over every 12 months	Covered 100%
Routine Colorectal Cancer Screening For all members 50 and over every 12 months	Covered 100%
Routine Bone Mass Measurement One exam every 12 months	Covered 100%

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA HEALTH INC

Additional Medicare Preventive Services* **	Covered 100%
Routine Eye Exam	Covered 100%
Direct access to participating providers. One annual exam.	
Routine Hearing Screening	Covered 100%
One exam every 12 months	
PHYSICIAN SERVICES	**Network Providers**
Primary Care Physician Visits	
(Office hours)	$15 copay
(After Office Hours)	$15 copay
Physician Specialist Visits	$25 copay
Podiatry Services	$25 copay
Limited to Medicare covered benefits only	
Allergy Testing/Treatment	$25 copay
For initial testing by a specialist; PCP copay for routine injections at PCP office with or without physician encounter	
DIAGNOSTIC PROCEDURES	**Network Providers**
Outpatient Diagnostic Laboratory and X-Ray	Covered 100%
EMERGENCY MEDICAL CARE	**Network Providers**
Urgently Needed Care	$65 copay
Emergency Room; Worldwide (waived if admitted)	$65 copay
Ambulance Services	Covered 100%
HOSPITAL CARE	**Network Providers**
Inpatient Hospital Care	Covered 100%
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Outpatient Surgery	Covered 100%
The member cost sharing applies to covered benefits incurred during a member's outpatient visit.	
MENTAL HEALTH SERVICES	**Network Providers**
Inpatient Mental Health Care	Covered 100%
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	

PLAN DESIGN AND BENEFITS
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Outpatient Mental Health Care The member cost sharing applies to covered benefits incurred during a member's outpatient visit.	$25 copay
ALCOHOL/DRUG ABUSE SERVICES	**Network Providers**
Inpatient Substance Abuse (Detox and Rehab) The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered 100%
Outpatient Substance Abuse (Detox and Rehab) The member cost sharing applies to covered benefits incurred during a member's outpatient v	Covered 100%
OTHER SERVICES	**Network Providers**
Skilled Nursing Facility (120 days per Medicare benefit period; prior authorization from HMO required) The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	Covered 100%
Home Health Agency Care	Covered 100%
Hospice Care	Covered by Medicare at Medicare certified Hospice.
Outpatient Rehabilitation Services (speech, physical, cardiac and occupational)	$25 copay
Chiropractic Services For manual manipulation of the spine to the extent covered by Medicare	$15 copay
Durable Medical Equipment/Prosthetic Devices	Covered 100%
Diabetic Supplies	No copay for strips, lancets, and glucometer.
Outpatient Complex Radiology: **CAT/ PET/ MRI** **Radiation Therapy**	 Covered 100% $25 copay
Outpatient Dialysis	$25 copay
Medicare Part B Prescription Drugs	Covered 100%
Dental *	Discounts where available

PLAN DESIGN AND BENEFITS
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Vision Eyewear Allowance	Lens Discounts
Hearing Aid Reimbursement	Discounts where available
Coaching One phone call per week	Included

* Dental Benefits are not available in all service areas. Refer to your plan documents for a complete description of the benefits or discounts available.

*** Additional Medicare Preventive Services include ultrasound screening for abdominal aortic aneurysm (AAA), cardiovascular disease screening, diabetes screening tests, diabetes self-management training (DSMT), medical nutrition therapy, glaucoma screening, smoking & tobacco use cessation counseling, HIV screening and annual wellness visit.

Benefits, limitations, service areas and premiums are subject to change on January 1 of
Members must be entitled to Medicare Part A and continue to pay the Part B premium and Part A, if applicable.
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• Plastic or cosmetic surgery unless medically necessary;
• Custodial care;
• Experimental procedures or treatments beyond Original Medicare limits;
• Routine foot care that is not medically necessary
• Outpatient Prescription Drugs except those covered under Original Medicare Part B.

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA HEALTH INC

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Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Information is believed to be accurate as of the production date; however, it is subject to change. In the event of a conflict or inconsistency between this material and plan documents, the terms of the plan document shall govern.

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2012 Aetna Medicare

This is the end of this plan benefit summary

Aetna Extras[SM] As an Aetna Medicare plan member, you get access to programs and services, tools and information—all extras—to help protect your health and health care dollars.

Health and wellness discounts[1]	
Aetna Vision[SM] **discount program**	Save on routine eye exams and select items and services, including LASIK surgery.
Aetna Hearing[SM] **discount program**	Save on hearing aids, comprehensive hearing tests and hearing-aid services from licensed professionals in certain areas.
Aetna Fitness[SM] **discount program**	Access preferred rates on gym memberships through the GlobalFit® network as well as discounts on at-home weight-loss programs, home fitness options and one-on-one health coaching services; not available in all states.
Aetna Natural Products and Services[SM] **discount program**	Offers reduced rates on acupuncture, chiropractic care, massage therapy and dietetic counseling through ChooseHealthy® program.* Get discounts on over-the-counter vitamins, herbal and nutritional supplements and natural products. Through Vital Health Network, you can receive a discount on online consultations and alternative remedies provided by medical doctors for a variety of conditions.
Aetna Weight Management[SM] **discount program**	Save on some of today's most popular weight loss programs, diet and meal plans.**
The Aetna Book[SM] **discount program**	Access discounts on books and other items purchased from the American Cancer Society Bookstore, the MayoClinic.com Bookstore and, for yoga-related titles, Pranamaya.com.

Discounts on other products and memberships including:

- MEM-X vocal memory aids, reminding you at a precise date and time of whatever it is you'd like to do, from making a phone call to taking a medication.
- Sonic toothbrushes and water-jet flossers from Waterpik.®
- Epic Dental products, such as gum, toothpastes and mouth rinses.
- Aging with Grace, LLC (AWG)—a national assistance program for members and their caregivers. AWG can help create a senior care plan by educating, coordinating and facilitating through the many options available, including access to accredited VA claims agents for veterans. Aetna Medicare members receive an exclusive discount on the annual AWG membership fee.

Discount programs provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Discounts do not apply to some discount vendor plans, programs, food and/or products. Aetna may receive a percentage of the fee you pay to a discount vendor. Information is believed to be accurate as of the production date; however it is subject to change.

[1] The products and services described are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the Aetna Medicare Plan grievance process.

*The ChooseHealthy program is made available through American Specialty Health Networks, Inc. (ASH Networks) and Healthyroads, Inc., subsidiaries of American Specialty Health Incorporated (ASH). ChooseHealthy is a federally registered trademark of ASH and used with permission herein.

**Discounts do not apply to some plans, programs, food and/or products.

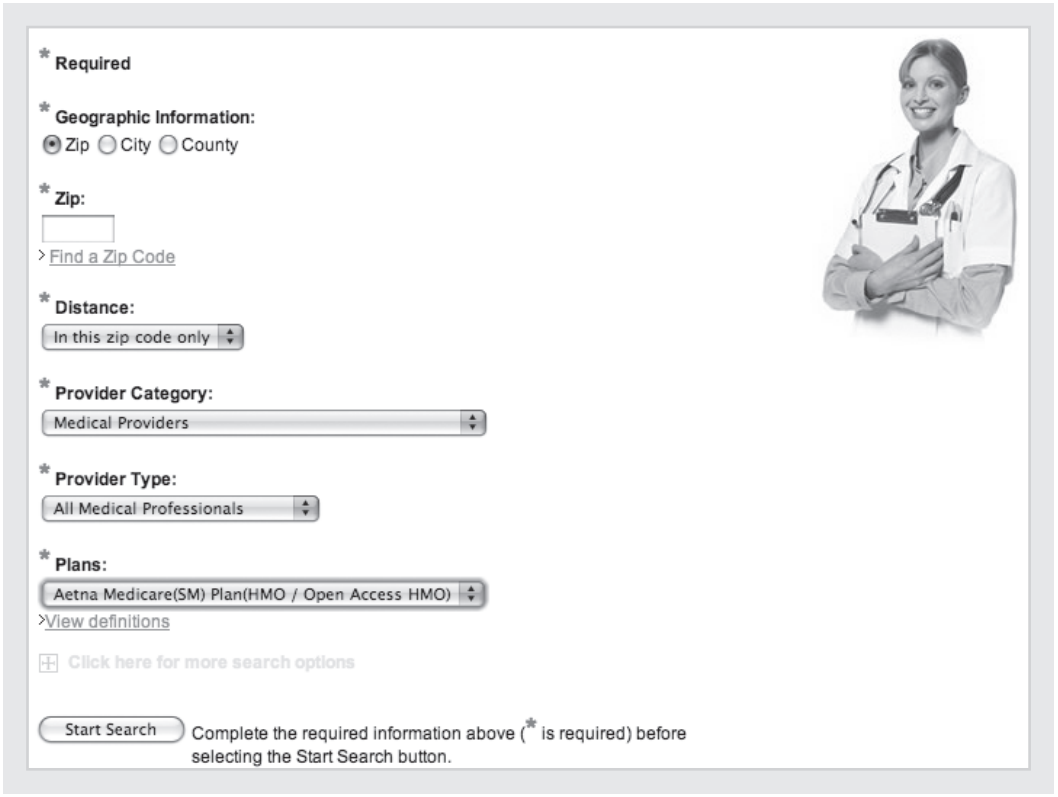
Health and wellness programs[1]	
Aetna Health Connections℠ disease management program	Offers educational materials and resources designed to help you live better with conditions such as diabetes, heart problems, asthma or arthritis.
Annual preventive reminders	Can help you remember to get important vaccinations, like flu shots, and colorectal cancer screenings.
Women's health reminders	Receive timely screening reminders for breast and cervical cancers.
Nurse case managers	Get personalized support for chronic and/or serious health conditions from specially trained medical professionals.
Informed Health® Line[1]	Talk directly with our experienced registered nurses about thousands of health topics using our 24-hour toll-free number.
Healthy lifestyle coaching	Speak to a licensed professional by phone to develop a specific program based on your health needs; learn how to manage weight and/or stress, quit smoking and maintain good health.
National Medical Excellence Program®	Offers access to our national Institutes of Excellence™ Transplant Network for transplants and transplant-related services. It includes medical management through the recovery period. Case management is also provided for members with rare or complex conditions requiring specialized treatment.
Patient safety through care considerations	Get timely alerts and additional reminders that can help you stay healthy. These messages may warn you of potentially dangerous drug combinations, or remind you of important tests and screenings.

[1] While only your doctor can diagnose, prescribe or give medical advice, the Informed Health Line nurses can provide information on more than 5,000 topics. Contact your doctor first with any questions or concerns regarding your health care needs. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professionals.

Tools

Personal health record	Keep track of health information online and get tips on alternative therapies.
Aetna Navigator®	View claims, print a temporary ID card and more, online.
Aetna Smartsource℠	Get information specific to you, based on where you live and your particular health plan.
Aetna Intelihealth®	View educational illustrations and interactive online features to learn about health care.
Health risk assessment tools	Assess your health care needs; manage health conditions.
DocFind®	Locate physicians, hospitals, pharmacies and other participating health care professionals with this online search tool. Search by name, zip code, city, state, specialty and/or hospital affiliation.

Locate a network provider or hospital near you by using DocFind,® our online provider directory at www.aetnaretireeplans.com, and click on Find a Doctor or call the number listed under “Contact Us” on the Aetna welcome page of this booklet.



What materials should I expect as a PPO (ESA) or HMO Open Access member?

See the chart below for what you can expect once you are enrolled.

What is it?	How will I receive?	When should I expect it?
Plan confirmation letter A letter informing you that we have confirmed with the Centers for Medicare & Medicaid Services (CMS) that you are approved to become a member of our plan.	U.S. Mail	After enrollment
Aetna Medicare identification (ID) card This is the card you show to providers prior to receiving services. If you need to obtain services before you receive your ID card, present the Plan Confirmation Letter and/or Enrollment Application to your provider as documentation that you have elected our plan.	U.S. Mail	Within 10 calendar days after CMS confirms enrollment
Health risk survey We will call to ask general questions regarding your health. You can also complete the survey on paper and mail it back.	Several attempts by phone, then U.S. Mail	After enrollment
Plan documents You will also receive several plan documents to help you understand and use your plan. They include the Evidence of Coverage, a Schedule of Copayments and a provider directory. If you are enrolled in a plan with Medicare Prescription Drug coverage, you will also receive a prescription drug formulary.	U.S. Mail	Within 10 days of confirmed enrollment or by the last day of the month prior to the enrollment effective date, whichever comes first

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-307-4830. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-307-4830. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-800-307-4830。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-800-307-4830。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-307-4830. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-307-4830. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-307-4830 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-307-4830. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-307-4830 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-307-4830. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على بمساعدتك. هذه مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-703-0384. سيقوم شخص ما يتحدث العربية خدمة مجانية.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-307-4830. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-307-4830. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-307-4830. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-307-4830. Ta usługa jest bezpłatna.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-307-4830 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-307-4830 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

Important information about your health benefits

Aetna Medicare℠ Plans (HMO), Aetna Medicare℠ Plans (HMO) Open Access, Aetna Medicare℠ Plans (PPO), Medicare Advantage plan (PPO) with Extended Service Area (ESA), Aetna Medicare Plan (PPO) Part B Only Plan

Federal Medicare Advantage plan requirements govern and supersede any state or general disclosures contained within.

Table of Contents

58.28.310.1-GRP (10/12)

Understanding your plan of benefits

Aetna health benefits plans cover most types of health care from a doctor or hospital. But they do not cover everything. The plan covers recommended preventive care and care that you need for medical reasons. It does not cover services you may just want to have, like plastic surgery. It also does not cover treatment that is not yet widely accepted. You should also be aware that some services may have limits. For example, a plan may allow only one eye exam per year.

Not all of the information in this booklet applies to your specific plan

Most of the information in this booklet applies to all plans. But some do not. For example, not all plans have deductibles. Also, some plans do not require referrals and you may not need to pick a primary care physician (PCP).

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 Summary of Benefits and Evidence of Coverage. Information about those topics will only apply if the plan includes those rules.

Where to find information about your specific plan

Your plan documents list all the details for your plan, such as, what's covered, what's not covered and the specific amounts that you will pay for services. Plan documents include your Summary of Benefits, Evidence of Coverage and/or any riders and updates that come with them.

If you can't find your plan documents, call Member Services at **1-888-267-2637** or call the number on the back of your ID card to ask for a copy.

Getting help

Contact us

Member Services can help with your questions. To contact Member Services, call **1-888-267-2637** or call the number on the back of your ID card. You can also send Member Services an e-mail. Just go to your secure Aetna Navigator® member website at **www.aetna.com**. Click on "Contact Us" after you log on.

Member Services can help you:

- Understand how your plan works or what you will pay
- Get information about how to file a claim
- Get a referral
- Find care outside your area
- File a complaint or appeal
- Get copies of your plan documents
- Connect to behavioral health services (if included in your plan)
- Find specific health information
- Learn more about our Quality Management program
- And more

Help for those who speak another language and for the hearing impaired

Do you need help in another language? Member Services representatives can connect you to a special line where you can talk to someone in your own language. You can also get interpretation assistance for registering a complaint or appeal.

Language hotline – ***1-888-267-2637*** (140 languages are available. You must ask for an interpreter.) TDD ***711*** (hearing impaired only)

Ayuda para las personas que hablan otro idioma y para personas con impedimentos auditivos

¿Necesita ayuda en otro idioma? Los representantes de Servicios al Miembro le pueden conectar a una línea especial donde puede hablar con alguien en su propio idioma. También puede obtener asistencia de un intérprete para presentar una queja o apelación.

Línea directa: ***1-888-267-2637*** (Tenemos 140 idiomas disponibles. Debe pedir un intérprete.) TDD ***711*** (sólo para personas con impedimentos auditivos)

Search our network for doctors, hospitals and other health care providers

It's important to know which doctors are in our network. That's because some health plans only let you visit doctors, hospitals and other health care providers, such as labs, if they are in our network. Some plans allow you to go outside the network. But, you generally pay less when you visit doctors in the network.

Here's how you can find out if your health care provider is in our network.

- Log on to your secure Aetna Navigator member website at **www.aetna.com**. Follow the path to find a doctor and enter your doctor's name in the search field.
- Call us at **1-888-267-2637** or the number on the back of your ID card.

For up-to-date information about how to find inpatient and outpatient services, partial hospitalization and other behavioral health care services, please follow the instructions above. If you do not have Internet access and would like a printed list of providers, please contact Member Services at the toll-free number on your Aetna ID card to ask for a copy.

Our online directory is more than just a list of doctor's names and addresses. It also includes information about where the physician attended medical school, board certification status, language spoken, gender and more. You can even get driving directions to the office. If you don't have Internet access, you can call Member Services to ask about this information.

Costs and rules for using your plan

What you pay

You will share in the cost of your health care. These are called "out-of-pocket" costs. Your plan documents show the amounts that apply to your specific plan. Those costs may include:

Copay – A fixed amount (for example, $15) you pay for covered health care service. You usually pay this when you receive the service. The amount can vary by the type of service. For example, the copay for your primary doctor's office visit may be different than a specialist's office visit.

- Coinsurance – Your share of the costs of a covered service. Coinsurance is calculated as a percent (for example, 20%) of the allowed amount for the service. For example, if the health plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health plan pays the rest of the allowed amount.
- Deductible – Some plans include a deductible. The amount you owe for health care services before your health plan begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you have paid $1,000 for any covered health care services that are subject to the deductible. The deductible may not apply to all services. Other deductibles may apply at the same time.

The Inpatient Hospital and Emergency Room Deductibles are separate from your general deductible. For example, your plan may have an overall $1,000 deductible and also have a $250 Emergency Room Deductible. This means that you pay the first $1,000 before the plan pays anything. Once the plan starts to pay, if you go to the emergency room you will pay the first $250 of that bill.

Your costs when you go outside the network

Network-only plans

Aetna Medicare HMO and HMO Open Access plans are network-based plans. That means the plan covers health care services only when provided by a doctor who participates in the Aetna Medicare network. If you receive services from an out-of-network doctor or other health care provider, you will have to pay all of the costs for the services except for urgent or emergency situations and out-of-area renal dialysis or other services.

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.

Plans that cover out-of-network services

If you have the Aetna Medicare PPO plan, you may choose to visit doctors who participate in our network, or go outside the network for covered services. You can receive services from any provider that is licensed, eligible to receive Medicare and willing to accept your plan. We cover the cost of care differently, based on whether doctors, hospitals and other health care providers 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.

"In network" means we have a contract with the provider (doctor or hospital). The provider and Aetna have agreed to set rates for covered health care services. "In-network" doctors won't bill you for the difference between their standard rates and the rate they've agreed to with us. All you have to pay is your plan coinsurance or copay, along with any plan deductible. Network doctors will also handle any precertification requirements for services you may need.

"Out of network" means that we do not have a contract for discounted rates with that doctor. We don't know exactly what an out-of-network doctor will charge you. 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 more money out of your own pocket if you choose to use an out-of-network doctor.

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

This means that you are fully responsible for paying everything above the amount that Aetna allows for a service or procedure.

Aetna will always base payment to out-of-network provides on the Medicare allowable charge.

Some Aetna Medicare Plans (PPO) offer an Extended Service Area (ESA) and do not require a higher cost sharing for out-of-network providers.

How we pay doctors who are not in our network

When you choose to see an out-of-network doctor, hospital or other health care provider, Aetna pays for your health care using a rate based on the Original Medicare rate.

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.

Going in network just makes sense!

- We have negotiated discounted rates for you
- In-network doctors and hospitals won't bill you for costs above our rates for covered services
- You are in great hands with access to quality care from our national network

To learn more about how we pay out-of-network benefits visit **Aetna.com**. Type "how Aetna pays" in the search box.

Choose a primary care physician (PCP)

Under your plan, you may have to pick a primary care physician, or "PCP." You can designate any primary care physician who participates in the Aetna Medicare network and who is available to accept you. If you do not pick a PCP when required, your benefits may be limited or we may select a PCP for you. Even if not required by your plan, you can still choose a PCP if you want one.

That's because a PCP can get to know your health care needs and help you better manage your health care.

A PCP is the doctor you go to when you need health care. If it's an emergency, you don't have to call your PCP first. This one doctor can coordinate all your care. Your PCP will perform physical exams, order tests and screenings and help you when you're sick. Your PCP will also refer you to a specialist when needed.

Your Ob/Gyn acting as your PCP will provide the same services and follow the same guidelines as any other PCP. They will issue referrals to other doctors (if your plan requires referrals) and they will get all required approvals and comply with any preapproved treatment plans. See the sections about referrals and precertification for more about those requirements.

Tell us who you chose to be your PCP

Enter the name of the PCP you have chosen on your enrollment form. Or, call Aetna 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.

Referrals: Your PCP will refer you to a specialist when needed

If required by your plan, you may need to get a referral from your PCP before you can see a specialist. A "referral" is a written request for you to see a participating specialty care provider for services you need. Some doctors can send the referral right to your specialist for you.

Talk to your doctor to understand why you need to see a specialist. And remember to always get the referral before you receive the care (if required by your plan).

Remember these points about referrals:

- You do not need a referral for emergency care.
- If you do not get a referral when required, you may have to pay the bill yourself. If your plan lets you go outside the network, the plan will pay it as an out-of-network benefit.
- Your specialist might recommend treatment or tests that were not on the original referral. In that case, you may need to get another referral from your PCP for those services. Discuss this with your doctor before receiving treatment or tests.
- Women can go to an Ob/Gyn without a referral. See "PCP and referral rules for Ob/Gyns" below.
- Except in emergencies, you need a referral from your PCP for all inpatient hospital services.
- Referrals are valid for one year as long as you are still a member of the plan. Your first visit must occur within 90 days of the referral issue date.
- In plans that do not let you go outside the network, you can get a special referral if a network specialist is not available.

Referrals to hospitals
You may need services that cannot be performed at your PCP's usual hospital. In this case, your PCP can call us to find a hospital that participates in our network and that provides the services you need.

Referrals within physician groups
Some PCPs are part of a larger group of doctors. These PCPs will usually refer you to another doctor within that same group. If this group cannot meet your medical needs, you can ask us for a coverage exception to go outside this group. You may also need to precertify these services. And you may need permission from the physician group as well.

Direct Access: No referrals needed for HMO open access and PPO plans
Under Aetna Medicare Plan (HMO) Open Access and Aetna Medicare Plan (PPO) you may directly access participating providers without a PCP referral, subject to the terms and conditions of the plan and cost-sharing requirements.

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

PCP and referral rules for Ob/Gyns

A female member can choose an Ob/Gyn as her PCP. Women can also go to any obstetrician or gynecologist who participates in the Aetna Medicare network without a referral or prior authorization. Visits can be for checkups, including breast exam, mammogram and Pap smear, and for obstetric or gynecologic problems.

Also, an Ob/Gyn can give referrals for covered obstetric or gynecologic services just like a PCP. Just follow your plan's normal rules. Your Ob/Gyn might be part of a larger physician's group. If so, any referral will be to a specialist in that larger group. Check with the Ob/Gyn to see if the group has different referral policies.

Precertification: Getting approvals for services

Sometimes we will pay for care only if we have given an approval before you get it. We call that "precertification." Precertification is usually limited to more serious care like surgery or being admitted to a nursing home. Your Evidence of Coverage list all the services that require precertification. When you get care from a doctor in the Aetna network, your doctor takes care of precertification. But if you get your care outside our network, you must call us for precertification when that's required. If you don't, you may have to pay for the service. Even with precertification, if you receive covered services from an out-of-network provider, you will usually pay more.

Call us at **1-888-267-2637** or the number on the back of your ID card to begin the process. You must get approval before you receive the care.

Precertification is not required for emergency services.

What we look for when reviewing a precertification request

First, we check to see that you are still a member. And we make sure the service is a covered expense under your plan. We also look to see if you qualify for one of our case management programs. If so, one of our nurses may call to tell you about it and help you understand your upcoming procedure.

Information about specific benefits

Emergency and urgent care and care after office hours

An emergency medical condition means your symptoms are sudden and severe. If you don't get help right away, an average person with average medical knowledge will expect that you could die or risk your health. For a pregnant woman, that includes her unborn child.

Emergency care is covered anytime, anywhere in the world. If you need emergency care, follow these guidelines:

- Call 911 or go to the nearest emergency room. If a delay would not risk your health, call your doctor or PCP.
- Tell your doctor or PCP as soon as possible afterward. A friend or family member may call on your behalf.
- Emergency care services do not require precertification.

What to do outside your Aetna Medicare service area

For all Aetna Medicare plans, you are covered for emergency and urgently needed care when you're traveling. When you need care right away, go to any doctor, walk-in clinic, urgent care center or emergency room.

We'll review the information when the claim comes in. If we think the situation was not urgent, we might ask you for more information and may send you a form to fill out. Please complete the form, or call Member Services to give us the information over the phone.

If you receive emergency care outside your Aetna Medicare service area, your health care provider may not accept payment of your cost share (copay/coinsurance) in full. If the provider bills you for an amount above your cost share, you are not responsible for paying the amount. You should send the bill to the address listed on your member ID card and we will resolve any payment dispute with the provider.

Follow-up care for plans that require a PCP

You may need to follow up with a doctor after your emergency. For example, you'll need a doctor to take out stitches, remove a cast or take another set of X-rays to see if you've healed. Your PCP should coordinate all follow-up care. You will need a referral for follow-up care that is not performed by your PCP. You may also need to precertify the services if you go outside the network.

PPO plans: All in-network and out-of-network follow-up care will be covered under the terms and conditions of your plan.

After-hours care available 24/7

Call your doctor anytime if you have medical questions or concerns. Your doctor should have an answering service if you call after the office closes. You can also go to an Urgent Care center, which may have limited hours. To find a center near you, log on to **www.aetna.com** and search our list of doctors and other health care providers. Check your plan documents to see how much you must pay for urgent care services.

Behavioral health and substance abuse benefits

If you have an Aetna Medicare HMO or HMO Open Access plan, you must use behavioral health professionals who are in the Aetna Medicare network.

Here's how to get behavioral health services
- Emergency services – call 911.
- Call the toll-free Behavioral Health number on your Aetna ID card.
- If no other number is listed, call **1-888-267-2637**.

If you access a behavioral health professional who is not in the Aetna network, you are responsible for getting any required precertification. You can access most outpatient therapy services without precertification. However, you should first consult Member Services to confirm that any such outpatient therapy services do not require precertification.

Read about behavioral health provider safety

We want you to feel good about using the Aetna network for behavioral health services. Visit **www.aetna.com/docfind** and click the "Quality & Cost Info" link, then the "Get info on Patient Safety and Quality" link. No Internet? Call Member Services at **1-888-267-2637** to ask for a printed copy.

Behavioral health programs to help prevent depression

Aetna Behavioral Health offers two prevention programs specifically for Medicare members. A depression screening and treatment referral component is available to any Medicare member who:

- Is at high risk for complications due to a medical condition that was found during an enrollment screening
- Has had a cardiac valve replacement
- Are already involved in one of the Aetna Medical Disease Management programs

Breast reconstruction benefits

Notice regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

(1) all stages of 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 lymph edemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services at **1-888-267-2637**.

For more information, you can visit this U.S. Department of Health and Human Services website, **www.cms.hhs.gov/HealthInsReformforConsume/06_TheWomen'sHealthandCancerRightsAct.asp#TopOfPage** and this U.S. Department of Labor website: **www.dol.gov/ebsa/consumer_info_health.html.**

Transplants and other complex conditions

Our National Medical Excellence Program® (NME) is for members who need a transplant or have a condition that can only be treated at a certain hospital. You may need to use an Aetna Institutes of Excellence™ hospital to get coverage for the treatment. Some plans won't cover the service if you don't. We choose hospitals for the NME program based on their expertise and experience with these services. We also follow any state rules when choosing these hospitals.

Knowing what is covered

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 Member Services at **1-888-267-2637** or the number on the back of your ID card.

We have developed a patient-management program to help determine what health care services are covered under the health plan and the extent of such coverage. The program helps patients get appropriate health care and maximize coverage for those health care services.

Here are some of the ways we determine what is covered:

We check if it's "medically necessary"

Medical necessity is more than being ordered by a doctor. "Medically necessary" means your doctor ordered a product or service for an important medical reason. It might be to help prevent a disease or condition. Or to check if you have one. Or it might be to treat an injury or illness.

The product or service:

- Must meet a normal standard for doctors
- Must be the right type in the right amount for the right length of time and for the right body part. It also has to be known to help the particular symptom.
- Cannot be for the member's or the doctor's convenience

Only medical professionals can deny coverage if the reason is medical necessity. We do not give financial incentives or otherwise to Aetna employees for denying coverage.

Sometimes the review of medical necessity is handled by a physicians' group. Those groups might use different resources than we do.

If we deny coverage, we'll send you and your doctor a letter. The letter will explain how to appeal the denial. You have the same right to appeal if a physician's group denied coverage for medical necessity. You can call Member Services to ask for a free copy of the criteria we use to make coverage decisions. Or visit aetnamedicare.com. Then click on the link "Member Disclosure" at the bottom of page. Then choose the type of plan you have (with or without prescription coverage). Then click on "Health Care Professionals" tab and then "Policies & Guidelines" to read our policies. Doctors can write or call our Patient Management department with questions. Contact Member Services either online or at **1-888-267-2637** or the number on the back of your ID card for the appropriate address and phone number.

We study the latest medical technology
Aetna routinely reviews 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 determine if they should now be covered.

To review these innovations, we may:

- Study medical research and scientific evidence on the safety and effectiveness of medical technologies

- Consider position statements and clinical practice guidelines from medical and government groups, including the Federal Agency for Healthcare Research and Quality and the Centers for Medicare and Medicaid Services
- 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 Health Care Policies and Guidelines. You can find the bulletins at www.aetna.com, under Health Care Professionals – Policies and Guidelines – Health Care Policies and Guidelines.

No matter what your age, taking care of yourself is always important. To find screening and preventive steps for your health, go to www.aetna.com –Individuals and Families – Health and Wellness – Important health care topics for you – Screening Guidelines. Always consult with your physician about the specific steps you should take and options available to you.

We post our findings on www.aetna.com

After we decide if a product or service is medically necessary, we write a report about it. We call the report a Clinical Policy Bulletin (CPB).

CPBs tell if we view a product or service as medically necessary. They also help us decide whether to approve a coverage request. But your plan may not cover everything that our CPBs say is medically necessary. Each plan is different, so check your plan documents.

CPBs are not meant to advise you or your doctor on your care. Only your doctor can give you advice and treatment. Talk to your doctor about any CPB related to your coverage or condition.

You and your doctor can read our CPBs on our website at **www.aetna.com** under "Individuals & Families." No Internet? Call Member Services at **1-888-267-2637**. Ask for a copy of a CPB for any particular product or service.

We can help when more serious care is suitable

In certain cases, we review a request for coverage to be sure the service or supply is consistent with established guidelines. Then we follow up. We call this "utilization management review."

It's a three-step process:

First, we begin this process if your hospital stay lasts longer than what was approved. We verify that it is necessary for you to still be in the hospital. We look at the level and quality of care you are getting. We call this a "concurrent review."

Second, we begin planning your discharge (or, "discharge planning"). This process can begin at any time. We look to see if you may benefit from any of our programs. We might have a nurse case manager follow your progress. Or we might recommend that you try a wellness program after you get back home.

Third, after you are home, we may review your case. In this "retrospective review," we may look over your medical records and claims from your doctors and the hospital. We look to see that you got appropriate care. We also look for waste or unnecessary costs.

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 to guide these processes. When provider groups, such as independent practice associations, are responsible for these steps, they may use other criteria that they deem appropriate.

What to do if you disagree with us

If you are not satisfied with a response you received from us or with how we do business, please refer to the appropriate section within this enrollment brochure:

- Medicare Advantage Organization Determinations, Appeals and Grievances

Member rights & responsibilities

Know your rights as a member

You have many legal rights as a member of a health plan. You also have many responsibilities. You have the right to suggest changes in our policies and procedures, including our Member Rights and Responsibilities.

Below are just some of your rights. We also publish a list of rights and responsibilities on our website. Visit **www.aetnamedicare.com.** Then click on link for "Member Disclosure" at bottom of page and choose the type of plan you have (with or without prescription coverage). Then click "Your Member Rights" to view the list. You can can also call Member Services at **1-888-267-2637** or the number on the back of your ID card to ask for a printed copy.

Making medical decisions before your procedure

An "advanced directive" tells your family and doctors what to do when you can't tell them yourself. You don't need an advanced directive to receive care. But you have the right to create one. Hospitals may ask if you have an advanced directive when you are admitted.

There are three types of advanced directives:

- Durable power of attorney – name the person you want 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 CPR if your heart stops or a breathing tube if you stop breathing.

You can create an advanced directive in several ways:

- Ask your doctor for an advanced directive form.
- Pick up a 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 advanced directive.
- Create an advanced directive using computer software designed for this purpose.

Not satisfied with how we handle advanced directives? File a complaint with your State Survey 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. September 2010. Available at **http://familydoctor.org/online/famdocen/home/pat-advocacy/endoflife/003.html.** Accessed December 6, 2010.

Learn about our quality-management programs

We make sure your doctor provides quality care for you and your family. To learn more about these programs, go to our website at **www.aetnamedicare.com** and click on the link "Member Disclosure" at bottom of page. Then choose the type of plan you have (with or without prescription coverage). Then click on "Health Care Quality." You can also call Member Services to ask for a printed copy. See "Contact Us" on page 1.

We protect your privacy

We consider your personal information to be private. Our policies help us protect your privacy. By "personal information," we mean information about your physical condition, the health care you receive and what your health care costs. Personal information does not include what is available to the public. For example, anyone can find out what your health plan covers or how it works. It also does not include summarized reports that do not identify you.

Below is a summary of our privacy policy. For a copy of our actual policy, go to **www.aetna.com.** You'll find the "Privacy Notices" link at the bottom of the page. You can also write to:

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

Summary of the Aetna privacy policy
We have policies and procedures in place to protect your personal information from unlawful use and disclosure. We may share your information to help with your care or treatment and administer our health plans and programs. We use your information internally, share it with our affiliates, and we may disclose it to:

- Your doctors, dentists, pharmacies, hospitals and other caregivers
- Those who pay for your health care services. That can include health care provider organizations and employers who fund their own health plans or who share the costs.
- Other insurers
- Third-party administrators
- Vendors
- Consultants
- Government authorities and their respective agents

These parties must also keep your information private. Doctors in the Aetna network must allow you to see your medical records within a reasonable time after you ask for them.

Some of the ways we use your personal information include:

- Paying claims
- Making decisions about what to cover
- Coordinating payments with other insurers
- Preventive health, early detection, and disease and case management

We consider these activities key for the operation of our health plans. We usually will not ask if it's okay to share your information unless the law requires us to. We will ask your permission to disclose personal information if it is for marketing purposes. Our policies include how to handle requests for your information if you are unable to give consent.

Anyone can get health care

We do not consider your race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national origin when giving you access to care. Network providers are contractually obligated to the same.

We must comply with these laws:
- Title VI of the Civil Rights Act of 1964
- Age Discrimination Act of 1975
- Americans with Disabilities Act
- Laws that apply to those who receive federal funds
- All other laws that protect your rights to receive health care

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

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

Providers, in all settings, achieve recognition by submitting data that demonstrates they are providing quality care. The program constantly assesses key measures that were carefully defined and tested for their relationship to improved care; therefore, NCQA provider recognition is subject to change.

Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. For up-to-date information, please visit our DocFind® directory at **www.aetna.com** or, if applicable, visit the NCQA's new top-level recognition listing at **recognition.ncqa.org**.

Medicare Advantage Coverage Determinations, Appeals and Grievances

As a member of the Aetna Medicare Plan (HMO) or Aetna Medicare Plan (PPO), you have the right to request an organizational determination, which includes the right to file an appeal if we deny coverage for an item or service and the right to file a grievance. You have the right to request an organziational determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our determination. Aetna Medicare is required to process organizational determinations, appeals and grievances using the requirements and timeframes established by the Centers for Medicare and Medicaid Services (CMS), the agency that oversees the Medicare program. The following is a description of these processes.

For detailed information about our Aetna Medicare organizational determination, appeal and grievance processes, forms, copies of the Evidence of Coverage and our contact information, please refer to our Aetna Medicare website: **www.aetnamedicare.com**. Then click on the link for "Aetna Medicare Advantage Plan Exceptions, Appeals and Grievance web page and online forms."

Copies of the forms mentioned in this document and copies of our Evidence of Coverage documents can be found on our website at: **www.aetnamedicare.com**. Simply click on the link for "Help & Resources," and then "Download Documents."

If you do not have access to the internet, you may also contact Member Services with any questions you may have or for copies of the forms and other information available on our website. Please call **1-877-238-6211** (TTY/TDD:711) 7 days a week, from 8 a.m. to 8 p.m. all time zones.

Appointment of Representation
You or someone you name may communicate with us on your behalf to request an organizational determination or file a grievance or appeal. The person you name would be your "appointed representative." You may name a relative, friend, advocate, doctor, or anyone else to act for you. Other persons may already be authorized under State law to act for you. If you want someone to act for you who is not already authorized under State law, then you and that person must sign and date a statement that gives the person legal permission to be your appointed representative. If you would like to appoint a representative to assist you with the organizational determination, exceptions, appeals or grievance process, please print, complete and sign the CMS Appointment of Representative form (CMS-1696) available on our website and include it with your written request. You can also contact Member Services for a copy of this form.

The Medicare Advantage Grievance Process
A "grievance" is any complaint other than one that involves an organizational determination. You would file a grievance if you have any type of problem with us or one of our plan providers. Grievance issues can include complaints about quality of care, waiting times, or customer service. Grievances do not include complaints related to coverage or payment disputes. If you have a grievance, we encourage you to first call Aetna Member Services.

A grievance can be filed orally or in writing and must be filed within 60 days of the event or incident. Grievances will be resolved as expeditiously as the case requires based on the member's health status, but no later than 30 days from the date of receipt. Aetna or the member can take up to a 14-day extension. If we initiate an extension, we must notify you in writing and the letter must provide the reason for the delay. A quality-of-care complaint can be filed with Aetna or the Quality Improvement Organization (QIO). There is a Quality Improvement Organization (QIO) in each state.

A QIO has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. A QIO is an independent organization. It is not connected with our plan.

You should contact the QIO in your state in any of these situations:
- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or
- Comprehensive Outpatient Rehabilitation

Facility (CORF) services are ending too soon. Please refer to the Evidence of Coverage for the name and contact information of the QIO in your state.

You also have the right to ask for an "expedited" or "fast" grievance. An expedited or "fast" grievance is a type of complaint that must be resolved within 24 hours from the time you contact us. You have the right to request an expedited grievance if you disagree with:

- Our determination to take a 14-day extension on a coverage determination or appeal.
- Our denial of your request to expedite an organizational determination or an appeal for health services.

Aetna will track all oral and written grievances received, including the date received, type of grievance and final disposition of the grievance, and the date the complainant was notified of the final outcome or resolution.

If you would like to file an oral grievance, you may do so by calling the following toll-free Member Services number **1-800-282-5366** (TTY/TDD:711). Calls to these numbers are free. Hours of operation: 7 days per week, 8 a.m. to 8 p.m. all time zones. If you would like to file a grievance, you can mail us your written complaint or you may print and complete a copy of the Aetna Medicare Plans Grievance or Appeal Form. You can access the forms on our website at: **www.aetnamedicare.com.** Then click on the link for "Help & Resources," and then "Download Documents." or by contacting Member Services at the toll-free number on your ID card for copies. Written complaints should be mailed to the address indicated below or you may fax them to the following toll-free fax number:

Aetna Medicare Grievance and Appeals Unit
P.O. Box 14067
Lexington, KY 40512
Fax Number all States: **1-866-604-7092**

Medicare Advantage Organizational Determinations

You have the right to request an organizational determination if you want us to provide or pay for an item or service that you believe should be covered. We are making an organizational determination for you whenever we decide what is covered for you and how much we pay. In some cases we might decide a service is not covered or is no longer covered by Medicare for you. If you disagree with this organizational determination, you can make an appeal.

Standard Organizational Determination Process

If you request an organizational determination for an item or service you believe should be covered and we process your request as a standard organizational determination, we must give you a determination within 14 days of receiving your request. However, we can take up to 14 more calendar days if you ask for more time, or if we need information (such as medical records) that may benefit you. If we decide to take extra days to make the determination, we will tell you in writing. If you believe we should not take extra days, you can file a "fast complaint" also known as an expedited grievance about our determination to take extra days. When you file an expedited grievance, we will give you an answer to your grievance within 24 hours.

If we do not give you our answer within 14 days (or if there is an extended time period, by the end of that period), you have the right to appeal. If our answer is yes to part or all

of what you requested, we must authorize or provide the coverage we have agreed to provide within 14 days after we received your request. If we extended the time needed to make our determination, we will provide the coverage by the end of that extended period. If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no and you will have the right to appeal.

"Fast" Organizational Determination Process

If your health requires it we will give you a fast determination and will give you an answer within 72 hours of receipt of your request. However, we can take up to 14 more calendar days if we find that some information that may benefit you is missing, or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing. If you believe we should not take extra days, you can file a "fast complaint" also known as an expedited grievance about our determination to take extra days. We will call you as soon as we make the determination.

If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. If our answer is yes to part or all of what you requested, we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our determination, we will provide the coverage by the end of that extended period. If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no and you will have the right to appeal.

To get a fast determination, you must meet two requirements:

- You can get a fast determination only if you are asking for coverage for medical care you have not yet received. (You cannot get a fast determination if your request is about payment for medical care you have already received.)
- You can get a fast determination only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.

If your doctor tells us that your health requires a "fast determination," we will automatically agree to give you a fast determination. If you ask for a fast determination on your own, without your doctor's support, we will decide whether your health requires that we give you a fast determination. If we decide your medical condition does not meet the requirements for a fast determination you will be notified in writing and the letter will explain your additional rights.

If you would like to request an organizational determination, you may do so by calling the following toll-free Member Services numbers: **1-800-282-5366** (TTY/TDD:711). Calls to these numbers are free. Hours of operation: 7 days per week, 8 a.m. to 8 p.m. all time zones. If you or your doctor would like to file a written organizational determination request, you can mail to the address indicated below:

Aetna Medicare Precertification Unit
P.O. Box 14079
Lexington, KY 40512-4079

Medicare Advantage Appeal Rights
As a member of the Aetna Medicare Plan (HMO) or Aetna Medicare Plan (PPO), you have the right to appeal any determination resulting in Aetna's failure to provide coverage for or pay for what you believe are covered benefits and services. These include:

1. Reimbursement for coverage of emergency or urgently needed services.
2. A denied claim for coverage of health care services that you believe should have been reimbursed by Aetna.
3. Coverage for an item or service that you have not received but which you believe should be covered.
4. Any determination to discharge you from the hospital if you believe it is too early to do so. (Note: In this case, a notice will be given to you with information about how to appeal to a Medicare Quality Improvement Organization (QIO). You will remain in the hospital while the QIO reviews the determination. You will not be held liable for charges during this period regardless of the outcome of the review. Refer to your Evidence of Coverage for the QIO in your area.)
5. Reductions or terminations of coverage for what you feel are medically necessary covered services. (Note: If the coverage that will be stopped is for home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, a notice will be given to you with information about how to appeal to a Medicare Quality Improvement Organization (QIO). There is a Quality Improvement Organization (QIO) in each state.)

A QIO has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. A QIO is an independent organization. It is not connected with our plan.

You should contact the QIO in your state in any of these situations:
- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or
- Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Please refer to the Evidence of Coverage for the name and contact information of the QIO in your state.

Aetna has a Medicare Standard Appeals Process and a Medicare Expedited Appeals Process. The following is a general explanation of these important processes.

Medicare Advantage Standard Appeals Process
Aetna must notify you in writing of any determination to deny a claim or service. The notice must state the reasons for the denial and also must inform you of your right to file an appeal. If you decide to proceed with the Medicare Standard Appeals Process, the following steps will occur:

1. You must submit a written request for appeal to Aetna. You must submit your written request within sixty (60) calendar days of the date of the notice of the adverse coverage determination. The sixty (60) day limit may be extended for good cause. Please include in your written request the reason why you could not file within the sixty (60) day timeframe.

If you would like to initiate an appeal request, you may submit your request in writing or you may

print and complete the Aetna Medicare Plans Grievance or Appeal Form and fax or mail it to Aetna. You can access the forms on our website at: **www.aetnamedicare.com.** Then click on the link for "Help & Resources," and then "Download Documents." Or you can contact or by contacting Member Services at the toll-free number on your ID card for copies.

Aetna Medicare Grievance & Appeals Unit
P.O. Box 14067
Lexington, KY 40512
Fax Number all States: **1-866-604-7092**

Aetna will conduct the reconsideration and notify you in writing of the determination, using the following timeframes:

a) Request for Services. If the appeal is for a denied service, we must notify you of the reconsidered determination as expeditiously as your health requires, but no later than thirty (30) calendar days from receipt of your request. We may extend this timeframe by up to fourteen (14) calendar days if you request the extension or if we need additional information and the extension of time benefits you. Our reconsidered determination will be made by a person(s) not involved in the initial determination.

b) If you disagree with our determination to extend the time frame, you have the right to request a "fast complaint" also known as an expedited grievance about our determination to take extra days. When you file a "fast" or expedited grievance, we will give you an answer to your grievance within 24 hours.

c) Request for Payment. If the appeal is for a denied claim, Aetna must notify you of the reconsidered determination no later than sixty (60) calendar days after receiving your request for a reconsidered determination. Our reconsidered determination will be made by a person(s) not involved in the initial determination. You may present or submit relevant facts and/or additional evidence for review either in person or in writing to Aetna.

2. If we decide fully in your favor on a request for a service, we must provide or authorize the requested service within thirty (30) calendar days of the date we received your request for appeal. If we extended the time needed to make our determination, we will provide the coverage by the end of that extended period. If we decide fully in your favor on a request for payment, we must make the requested payment within sixty (60) calendar days of the date we received your request for appeal.

3. If we decide to uphold the original adverse determination, either in whole or in part, we will automatically forward the entire file to an Independent Review Organization designated by CMS for a new and impartial review. We must send the file to the Independent Review Organization within thirty (30) calendar days of a request for service and within sixty (60) calendar days of a request for payment.

4. If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send the request on to Level 2 of the appeals process where it will be reviewed by an Independent Review Organization designated by CMS.

5. For cases submitted for review, the Independent Review Organization will make a reconsidered determination and notify you in writing of the reasons for the determination. If the Independent Review Organization upholds our determination, their notice will inform you of your right to a hearing before an Administrative Law Judge (ALJ).

6. If the Independent Review Organization decides in your favor, we must:

   a) Authorize the disputed service within 72 hours from the date we receive notice from the Independent Review Organization reversing the determination; or

b) Provide the disputed service as expeditiously as your health condition requires, but no later than fourteen (14) calendar days from the date we receive notice from the Independent Review Organization reversing the determination; or

c) Pay for the disputed service within thirty (30) calendar days from the date we receive notice from the Independent Review Organization reversing the determination.

7. If the Independent Review Organization does not rule fully in your favor, there are further levels of appeal:

If the amount in dispute meets the established CMS dollar threshold, you may request a hearing before an Administrative Law Judge (ALJ) by submitting a written request to Aetna, the Independent Review Organization or the Social Security Administration (SSA). The request must be sent within sixty (60) calendar days of the date of the Independent Review Organization notice that the reconsidered determination was not in your favor. This sixty (60) day notice may be extended for good cause.

Either you or Aetna may request a review of an ALJ determination by the Medicare Appeals Council (MAC), which may either review the determination or decline review.

If the amount in dispute meets the established CMS dollar threshold, either you or Aetna may request that a determination made by the MAC, or the ALJ, if the MAC has declined review, be reviewed by a Federal district court.

Any initial or reconsidered determination made by Aetna, Independent Review Organization, the ALJ, or the MAC can be reopened by any party (a) within 12 months, (b) within four (4) years for just cause, or (c) at any time for clerical correction of an error or in cases of fraud.

Medicare Advantage Expedited Appeals Process

1. You may file a request for an expedited appeal for the denial of coverage for services you believe you need and where you feel that applying the standard appeal process could jeopardize your health. If Aetna decides that the timeframe for the standard process could seriously jeopardize your life, health or ability to regain maximum function, the review of your request will be expedited. If you disagree with a determination to discharge you from the hospital, see the next section.

2. A physician may file a request for an expedited appeal on your behalf. Aetna must provide an expedited appeal if the physician indicates that applying the standard appeal process could seriously jeopardize your life, health or ability to regain maximum function.

3. Aetna will notify you and/or the physician of our determination as expeditiously as your health condition requires but no later than 72 hours after receiving the request. We may extend this timeframe by up to fourteen (14) calendar days if you request the extension or if we need additional information and the extension of time benefits you.

4. If you disagree with our determination to extend the time frame, you have the right to request a "fast complaint," also known as an expedited grievance. Aetna's written notification will provide instructions and the timeframes associated with the expedited grievance process. When you file an expedited grievance, we will give you an answer to your grievance within 24 hours.

5. To request an expedited appeal, you may call **1-800-932-2159**. You may fax, mail or hand deliver your written request to Aetna. If you write, the 72-hour review timeframe will not begin until your request is received.

   Aetna Medicare Grievance and Appeals Unit
   P.O. Box 14067
   Lexington, KY 40512
   Fax Number all states: **1-866-604-7092**

6. If Aetna determines that your request is not time-sensitive, where your health is not seriously jeopardized, Aetna will notify you verbally and in writing and will automatically begin processing your request under the standard appeal process.
7. If you disagree and believe the review should be expedited, you may file a "fast complaint," also known as an expedited grievance, with Aetna. The written notice will include instructions on how to file an expedited grievance. When you file an expedited grievance, we will give you an answer to your grievance within 24 hours.
8. We must give you our answer within 72 hours after we receive your appeal. We will give you our answer sooner if your health requires it. If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization.

   If our answer is yes to part or all of what you requested, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.

   If our answer is no to part or all of what you requested, we will automatically forward the entire file to an Independent Review Organization designated by CMS for a new and impartial review.
9. For cases submitted for review, the Independent Review Organization will make a reconsidered determination within 72 hours and notify you in writing of the reasons for the determination. If the Independent Review Organization upholds our determination, their notice will inform you of your right to a hearing before an Administrative Law Judge as described in Step 7 under the standard appeals process.
10. If the Independent Review Organization decides in your favor, we must authorize the disputed service within 72 hours from the date we receive notice from the Independent Review Organization reversing the determination; or provide the disputed service as expeditiously as your health condition requires, but no later than fourteen (14) calendar days from the date we receive notice from the Independent Review Organization reversing the determination; or pay for the disputed service within thirty (30) calendar days from the date we receive notice from the Independent Review Organization reversing the determination.

Health insurance plans are offered by Aetna Life Insurance Company (Aetna).

The benefit information provided herein is a brief summary, not a comprehensive description of benefits. For more information contact the plan. Limitations, copayments, and restrictions may apply. Benefits, formulary, pharmacy network, premium, and/or copayments/coinsurance may change on January 1, 2013. You must be entitled to Medicare Part A and continue to pay your Part B premium and Part A, if applicable. Medicare beneficiaries may enroll in a plan only during specific times of the year. To obtain additional information, please contact Aetna Medicare at **1-888-267-2637** or the number on the back of your ID card (TTY/TDD:711), from 8 a.m. to 8 .pm., 7 days a week. This material is for informational purposes only. 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. 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. Pharmacy participation is subject to change.

This information is available for free in other languages. Please contact our Customer Service number at **1-888-267-2637** or the number on the back of your ID card (TTY/TDD:711) for additional information. Hours of operation: 7 days per week, 8 a.m. to 8 p.m.

Esta información está disponible en otros idiomas de manera gratuita. Si desea más información, comuníquese con Servicios al Cliente al **1-888-267-2637** or the number on the back of your ID card (TYY/TDD:711). Horario de atención: los 7 días de la semana, de 8 a.m. a 8 p.m.

www.aetnaretireeplans.com

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