AARP® Essential Premier Health Insurance

Insured by Aetna

A guide to understanding your choices and selecting an insurance plan

AARP® | Essential Premier Health Insurance insured by aetna™

49.39.300.1-OH (1/13)

AARP® Essential Premier Health Insurance Plan is the name of the plan underwritten for AARP members by Aetna Life Insurance Company. In some states, individuals may qualify as a business group of one and may be eligible for guaranteed issue, small group health plans.

AARP Essential Premier Health Insurance plans are medically underwritten by Aetna Life Insurance Company and to the extent permitted by law you may be declined coverage in accordance with your health condition.

AARP® | Essential Premier Health Insurance
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Visit: **www.PremierHealthCoverage.com**

Health Care Reform – what you need to know

The Federal Health Care Reform Legislation, known as The Patient Protection and Affordable Care Act, was signed into law on March 23, 2010.

Since then, Aetna has periodically updated the AARP Essential Premier Health Insurance Plan, insured by Aetna to include any necessary changes. It is important for you to know that your plan will always comply with all of the federal health care reform legislation.

Women's Preventive Health Benefits – new changes effective August 1, 2012

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

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

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

Welcome to AARP® Essential Premier Health Insurance Plan, insured by Aetna.

Nothing is more important than your health.

That's why health insurance coverage is such an essential part of life for AARP members.

Did you or your spouse just leave an employer's insurance plan?
Are you looking for something less expensive than COBRA?
Want to switch from your current plan?

AARP Essential Premier Health Insurance offers quality coverage.
An excellent value, this plan was custom-designed exclusively for AARP members aged 50 to 64 and their dependents.

This health insurance plan is endorsed by AARP, and it is insured by Aetna.
One of the nation's leading health insurers, Aetna has been in business for over 150 years.
Many of these plans offer:

- Coverage for you, your spouse, your dependent children and/or grandchildren
- Prescription drug, doctor, hospital and preventive care coverage
- High-deductible plans compatible with tax-advantaged Health Savings Accounts (HSAs)
- Aetna's nationwide network of doctors and hospitals

Here's what to do next:

- Read through this guide
- Decide which plan best fits your needs
- Complete the application
- Mail it in the enclosed envelope

Questions, want a price quote, or want to apply by phone?

- Call a company representative toll-free at 1-866-660-4081 (TTY: 1-800-232-7773).
- Ask about speaking to an authorized independent health insurance agent* in your area.
- You can also apply online at www.PremierHealthCoverage.com.

Thanks for inquiring about this health insurance plan designed just for AARP members.
It represents a strong combination of quality and value in health insurance.

*AARP and its affiliate are not insurance agencies or carriers and do not employ or endorse individual agents, brokers, producers, representatives, or advisors.

AARP® | Essential Premier Health In
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Your guide to AARP Essential Premier Health Insurance

Here's how to use this guide to select and apply for AARP® Essential Premier Health Insurance, insured by Aetna:

A. **Confirm that AARP Essential Premier Health Insurance is available in your area. Section A.**

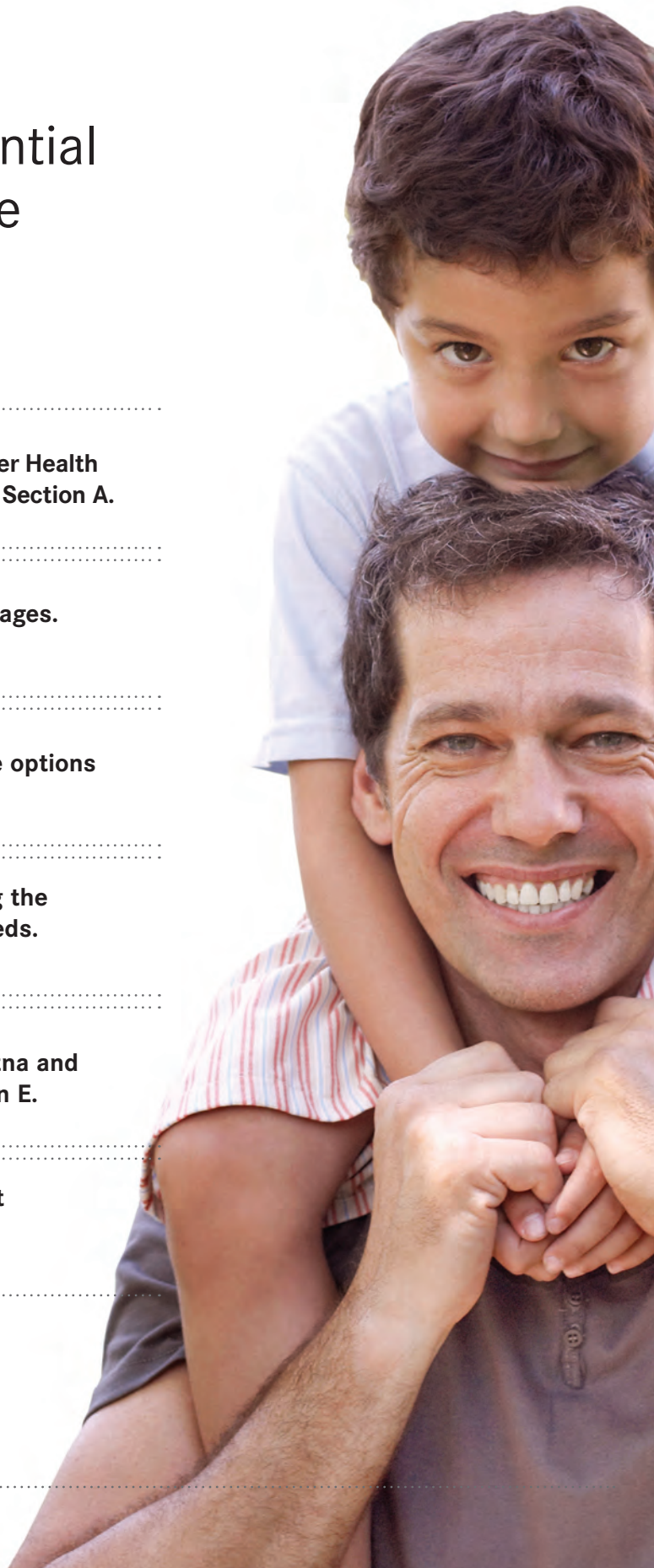
B. **Check out the plan's many advantages. Section B.**

C. **Learn about the types of coverage options available to you. Section C.**

D. **Get some helpful tips on choosing the right coverage for your unique needs. Section D.**

E. **Compare the plans insured by Aetna and their features side by side. Section E.**

F. **Apply online, by mail, or ask about speaking to a local authorized independent agent.* Section F.**



* AARP and its affiliate are not insurance agencies or carriers and do not employ or endorse individual agents, brokers, producers, representatives, or advisors.

A. Is AARP Essential Premier Health Insurance available in your area?

Covered counties* are shaded in grey and listed on the opposite page.

Which doctors and hospitals are in the network?
Visit www.PremierHealthCoverage.com
Or call a representative toll-free at
1-866-660-4081 (TTY: 1-800-232-7773)

Network map

Ohio

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

Covered* Network counties**

Adams
Adams
Allen
Ashland
Ashtabula
Athens
Auglaize
Belmont
Brown
Butler
Carroll
Champaign
Clark
Clermont
Clinton
Columbiana
Coshocton
Crawford
Cuyahoga
Darke
Defiance
Delaware
Erie
Fairfield
Fayette
Franklin
Fulton
Gallia
Geauga
Greene
Guernsey
Hamilton
Hancock
Hardin
Harrison
Henry
Highland
Hocking
Holmes
Huron
Huron
Jackson
Jefferson
Knox
Lake
Lawrence
Licking
Logan
Lorain
Lucas
Madison
Mahoning
Marion
Medina
Meigs
Mercer
Miami
Monroe
Montgomery
Morgan
Morrow
Muskingum
Noble
Ottawa
Paulding
Perry
Pickaway
Pike
Portage
Preble
Putnam
Richland
Ross
Sandusky
Scioto
Seneca
Shelby
Stark
Summit
Trumbull
Tuscarawas
Union
Van Wert
Vinton
Warren
Washington
Wayne
Williams
Wood
Wyandot

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B. The many advantages of AARP Essential Premier Health Insurance

These health insurance plans offer many advantages to you, including:

Family coverage

The plan offers you and your family quality coverage at an excellent value. You can apply for coverage for yourself, and include your spouse or domestic partner, children and grandchildren. Coverage can include prescription drugs, doctor visits, hospitalization and preventive care.

Choice

Choose from a wide range of health insurance plans, with different price and coverage levels. You can select from three (3) options: robust Premier Preferred Provider Organization plans; High-Deductible plans with tax-advantaged health savings accounts; or more affordable Preventive and Hospital Care plans with limited benefits.

Tax advantages

Our High Deductible plans are compatible with tax-advantaged Health Savings Accounts (HSAs). You can contribute money to your HSA tax free. That money earns interest tax free. And qualified withdrawals for medical expenses are tax free, too.

Coverage when you travel

Like to travel? You're covered by a nationwide network of doctors and hospitals that accept Aetna's negotiated fees. There is even reimbursable coverage for health care services when you travel internationally.

Help with health information

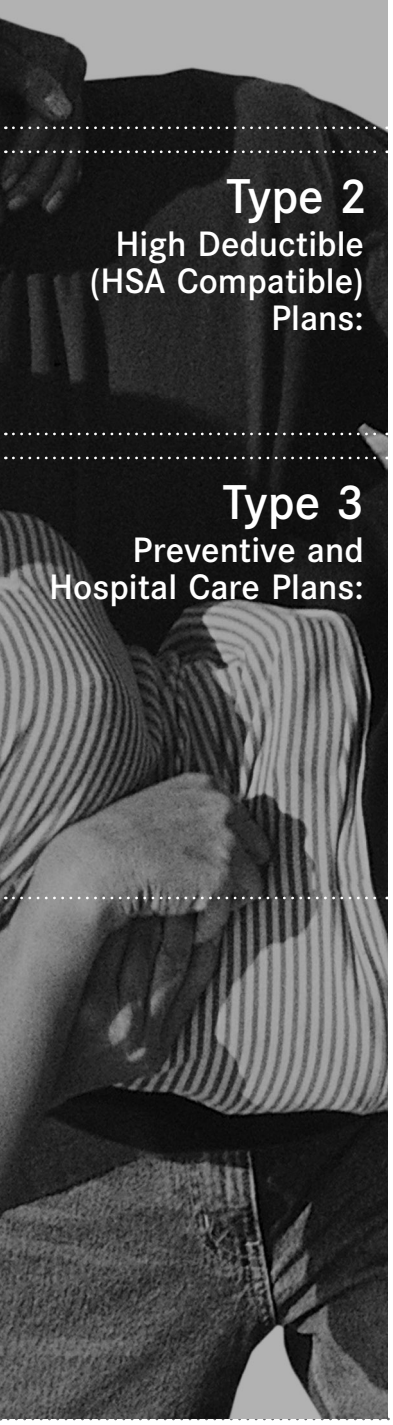
Need health information fast? Through Aetna's secure, award winning website, we offer you access to reliable health tools and resources to help you better understand and manage your health benefits. You can also call a registered nurse toll-free 24/7 through Aetna's Informed Health® Line.

To the extent permitted by law, AARP® Essential Premier Health Insurance plans are medically underwritten by Aetna and you may be declined coverage in accordance with your health condition. If declined coverage, you may be federally eligible under the Health Insurance Portability and Accountability Act (HIPAA) or a special guaranteed issue plan under your state's laws and regulations. Health insurance plans contain exclusions and limitations.

Why Aetna?

Why did AARP select Aetna to make available health insurance for its members? Because Aetna is focused on addressing the needs of people aged 50 to 64, when insurance coverage is often unavailable or unaffordable. In addition to receiving quality, affordable coverage, eligible AARP members gain access to Aetna's innovative and personalized tools and services to help make better health care decisions.

C. A variety of plans to fit a variety of needs



Type 1
Premier PPO Plans:

Robust healthcare coverage, competitive premiums

- An excellent combination of quality coverage and competitively priced premiums.
- The freedom to see doctors whenever you need to, with no referrals needed for covered services.
- Covers preventive care, prescription drugs, doctor visits, hospitalization and preventive medications at 100% before your deductible (no co-payment).
- No claim forms to fill out when you use a network provider.
- Three (3) plan options, based on an annual deductible of $1500, $2500 or $5000.

Type 2
High Deductible (HSA Compatible) Plans:

Tax advantages, lower premiums

- Lower monthly premiums, with a higher annual deductible.
- Covers preventative care, prescription drugs, doctor visits, and hospitalization.
- Should be paired with a Health Savings Account (HSA), which lets you pay for qualified medical expenses with tax-advantaged funds.
- See “HSA advantages” on the next page for details.
- Two (2) plan options, based on an annual deductible of $3000 or $5000.

Type 3
Preventive and Hospital Care Plans:

Basic coverage with limited benefits, lower premiums

- The most affordable premiums available.
- Covers preventive care, including annual GYN exam, well-child care and physical exam.
- Covers inpatient hospital stays, plus benefits for outpatient surgery, skilled nursing or home health care.
- Two plan options, based on an annual deductible of $1250 or $3000 (HSA compatible).

Note: This plan provides limited benefits only and does not constitute a major medical health insurance plan. It may not cover all expenses associated with your health care needs.

HSA advantages

A Health Savings Account (HSA) has many tax advantages. They are:

- You or an eligible family member can contribute to your HSA tax free.
- The dollars in your account earn interest tax free.
- When you take money out to pay for qualified health care expenses before or after the deductible is met, that's tax free, too.
- Any money you haven't used at the end of the plan year rolls over to the next year. You can allow your HSA account to grow over time and use it to help pay for future health related expenses. You never lose it.
- You own your HSA. If you change jobs or health insurance plans, the money in your account is always yours and can be used in conjunction with another health plan.
- If you are age 55 or older (until enrolled in Medicare), you can also make additional catch-up contributions to your HSA.

About premiums, deductibles and copays:

To get a plan with a lower monthly premium, look for one with a higher annual deductible or a higher copay (what you pay for a specific product or service when care is given).

A plan with higher monthly premiums typically has a lower deductible and/or copays.

Want to cover your children or grandchildren?

You can enroll dependent children or dependent grandchildren on your AARP Essential Premier Health Insurance plan.

Added coverage

We understand you're looking for more coverage. Aetna has answered. Check out the following benefits now available in all AARP Essential Premier plans:

- One eye exam every 12 months with no copay and no deductible when you see an in-network provider*.
- Enhanced hospice coverage with an unlimited lifetime maximum. The Aetna Compassionate Care℠ program provides additional support to members and their families who are confronting life-threatening illness and to help them access optimal care. A dedicated website provides online tools and information about advance directives and living wills, as well as tips on how to begin discussions about personal wishes at the end of life. More information can be found by visiting **www.AetnaCompassionateCareProgram.com/EOL/**.

Preventive care

Preventive care is covered beginning on the effective date of your policy, with no deductible applied for the following services (in network only):

- Flu shots (no copay; no physical exam needed).
- Regular office visits, routine GYN exams, and annual physical exams.
- Preventive colonoscopies and annual mammograms.
- Certain preventive medications covered on High Deductible Health Plans (no copay). Visit **www.PremierHealthCoverage.com** for a list of qualified medications.

* To determine which doctors are in the network, visit Aetna DocFind by clicking on "Find a Doctor" on **www.PremierHealthCoverage.com**.

D. Tips on selecting the right plan for you

Choosing a good health plan for you and your family can be confusing. Here's some help. This chart offers you some tips on selecting the right plan for your unique situation, priorities and budget. Look for what's most important to you on the left, and you'll find suggested plans on the right.

If	Then
If you want a lower deductible and are willing to pay a higher premium…	Premier $1500 or $2500
You use only basic health care services and want to keep your monthly premium payments lower…	Premier $5000 Preventive and Hospital Care $3000* High Deductible $5000
You don't want to pay a lot for frequent doctor visits…	Premier $1500
You want a balance of lower cost and quality coverage…	Premier $2500
You want to cap the amount you'll spend on total medical expenses each year…	Premier $1500
You want a plan that works with a tax-advantaged Health Savings Account…	High Deductible $3000 or $5000 Preventive and Hospital Care $3000*
You think robust coverage is more important than the amount you will pay…	Premier $1500

*This plan provides limited benefits only and does not constitute a major medical health insurance plan. It may not cover all expenses associated with your health care needs.

E. Compare the plans side by side

Easy-to-compare benefits charts

On the next two pages you'll see all the major features and benefits of each plan in chart form, making it easy to choose the plan that's right for you.

Have questions or want a quote?

Call a representative toll-free at 1-866-660-4081 (TTY: 1-800-232-7773).

Ask about authorized independent insurance agents in your area or visit www.PremierHealthCoverage.com to Find an Agent in your area.

Which doctors and hospitals are in the network?
Visit www.PremierHealthCoverage.com
Or call a representative toll-free at 1-866-660-4081 (TTY: 1-800-232-7773)

	PREMIER $1500 DEDUCTIBLE PLAN (You pay the amounts below)		PREMIER $2500 DEDUCTIBLE PLAN (You pay the amounts below)		PREMIER $5000 DEDUCTIBLE PLAN (You pay the amounts below)	
MEMBER BENEFITS	**In-Network**	**Out-of-Network†**	**In-Network**	**Out-of-Network†**	**In-Network**	**Out-of-Network†**
Deductible Individual / Family	$1,500/$3,000	$3,000/$6,000	$2,500/$5,000	$5,000/$10,000	$5,000/$10,000	$10,000/$20,000
Coinsurance (Member's Responsibility)	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Coinsurance Maximum Individual / Family	$1,500/$3,000	$1,500/$3,000	$2,500/$5,000	$2,500/$5,000	$2,500/$5,000	$2,500/$5,000
Out-of-Pocket Maximum *(Includes Deductible)* Individual / Family	$3,000/$6,000	$4,500/$9,000	$5,000/$10,000	$7,500/$15,000	$7,500/$15,000	$12,500/$25,000
Lifetime Maximum per Insured	Unlimited		Unlimited		Unlimited	
Non-Specialist Office Visit General Physician, Family Practitioner, Pediatrician or Internist	$25 copay ded. waived	40% after deductible	$30 copay ded. waived	40% after deductible	$40 copay ded. waived	40% after deductible
Specialist Visit	$35 copay ded. waived	40% after deductible	$40 copay ded. waived	40% after deductible	$50 copay ded. waived	40% after deductible
Hospital Admission	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Emergency Room	$100 copay** (waived if admitted) 20% after deductible		$100 copay** (waived if admitted) 20% after deductible		$100 copay** (waived if admitted) 20% after deductible	
Urgent Care	$75 copay, deductible waived	50% after deductible	$75 copay, deductible waived	50% after deductible	$75 copay, deductible waived	50% after deductible
Annual Routine GYN Exam Annual Pap	$0 copay ded. waived	40% after deductible	$0 copay ded. waived	40% after deductible	$0 copay ded. waived	40% after deductible
Maternity	Not covered *Except for pregnancy complications*		Not covered *Except for pregnancy complications*		Not covered *Except for pregnancy complications*	
Preventive Health Routine Physical	$0 copay ded. waived	40% after deductible	$0 copay ded. waived	40% after deductible	$0 copay ded. waived	40% after deductible
Lab / X-Ray	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Skilled Nursing In lieu of hospital *30 days per calendar year**	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Physical / Occupational Therapy *24 visits per calendar year**	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Home Health Care In lieu of hospital *30 visits per calendar year**	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
PHARMACY						
Pharmacy Deductible Individual / Family	$250/$500 NA to generic	$250/$500 NA to generic	$500/$1,000 NA to generic	$500/$1,000 NA to generic	$500/$1,000 NA to generic	$500/$1,000 NA to generic
Generic	$15 copay ded. waived	$15 copay plus 40% ded. waived	$15 copay ded. waived	$15 copay plus 40% ded. waived	$15 copay ded. waived	$15 copay plus 40% ded. waived
Preferred Brand	$25 copay after deductible	$25 copay plus 40% after ded.	$25 copay after deductible	$25 copay plus 40% after ded.	$25 copay after deductible	$25 copay plus 40% after ded.
Non-Preferred Brand	$40 copay after deductible	$40 copay plus 40% after ded.	$40 copay after deductible	$40 copay plus 40% after ded.	$40 copay after deductible	$40 copay plus 40% after ded.
Calendar Year Max per Individual	Unlimited		Unlimited		Unlimited	

* Maximum applies to combined in- and out-of-network benefits. For a full list of benefit coverage and exclusions refer to plan documents.

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

*** Aetna discount available.

HIGH DEDUCTIBLE $3000 PLAN (HSA COMPATIBLE) (You pay the amounts below)		HIGH DEDUCTIBLE $5000 PLAN (HSA COMPATIBLE) (You pay the amounts below)		PREVENTIVE & HOSPITAL $1250 DEDUCTIBLE PLAN (You pay the amounts below)		PREVENTIVE & HOSPITAL $3000 DEDUCTIBLE PLAN (HSA COMPATIBLE) (You pay the amounts below)	
In-Network	**Out-of-Network†**	**In-Network**	**Out-of-Network†**	**In-Network**	**Out-of-Network†**	**In-Network**	**Out-of-Network†**
$3,000/$6,000	$6,000/$12,000	$5,000/$10,000	$10,000/$20,000	$1,250/$2,500	$2,500/$5,000	$3,000/$6,000	$6,000/$12,000
0% after deductible	40% after deductible	0% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
$0/$0	$6,500/$13,000	$0/$0	$2,500/$5,000	$2,500/$5,000	$5,000/$10,000	$2,000/$4,000	$4,000/$8,000
$3,000/$6,000	$12,500/$25,000	$5,000/$10,000	$12,500/$25,000	$3,750/$7,500	$7,500/$15,000	$5,000/$10,000	$10,000/$20,000
Unlimited		Unlimited		Unlimited		Unlimited	
0% after deductible	40% after deductible	0% after deductible	40% after deductible	Not covered	Not covered	Not covered	Not covered
0% after deductible	40% after deductible	0% after deductible	40% after deductible	Not covered	Not covered	Not covered	Not covered
0% after deductible	40% after deductible	0% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
0% after deductible	40% after deductible	0% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
$0 copay after deductible	$0 copay after deductible	$0 copay after deductible	$0 copay after deductible	$100 copay** (waived if admitted) 20% after deductible		$100 copay** (waived if admitted) 20% after deductible	
$75 copay, deductible waived	50% after deductible	$75 copay, deductible waived	50% after deductible	$75 copay, deductible waived	50% after deductible	$75 copay, deductible waived	50% after deductible
$0 copay ded. waived	40% after deductible	$0 copay ded. waived	40% after deductible	$0 copay ded. waived	40% after deductible	$0 copay ded. waived	40% after deductible
Not covered *Except for pregnancy complications*		Not covered *Except for pregnancy complications*		Not covered *Except for pregnancy complications*		Not covered *Except for pregnancy complications*	
$0 copay ded. waived	40% after deductible	$0 copay ded. waived	40% after deductible	$0 copay ded. waived	40% after deductible	$0 copay ded. waived	40% after deductible
0% after deductible	40% after deductible	0% after deductible	40% after deductible	20% after ded. preoperative w/covered surgery only	40% after ded.	20% after ded. preoperative w/covered surgery only	40% after ded.
0% after deductible	40% after deductible	0% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
0% after deductible	40% after deductible	0% after deductible	40% after deductible	Not covered	Not covered	Not covered	Not covered
0% after deductible	40% after deductible	0% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
0% after deductible	40% after deductible	0% after deductible	40% after deductible	Not covered	Not covered	Not covered	Not covered
Integrated Medical/Rx Deductible		Integrated Medical/Rx Deductible		Not applicable	Not applicable	Not covered***	Not covered***
$0 copay after medical ded.	40% after med. ded.	0% after med. ded.	40% after med. ded.	$15 copay ded. waived	$15 copay plus 40% ded. waived	Not covered***	Not covered***
$0 copay after medical ded.	40% after med. ded.	0% after med. ded.	40% after med. ded.	Not covered***	Not covered***	Not covered***	Not covered***
$0 copay after medical ded.	40% after med. ded.	0% after med. ded.	40% after med. ded.	Not covered***	Not covered***	Not covered***	Not covered***
Unlimited		Unlimited		Unlimited		Not applicable	Not applicable

† Payment for out-of-network facility covered expenses is determined based on the Aetna Market Fee Schedule. Payment for out-of-network non-facility covered expenses is determined based on the negotiated charge that would apply if such services were received from a Network Provider.

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F. Three ways to apply*

Option one:
Apply online

1. Visit **www.PremierHealthCoverage.com**.
2. Enter and submit your state, ZIP code and birth date.
3. Use the helpful information and tools to choose the best plan for you. (Or call toll-free 1-866-660-4081 (TTY: 1-800-232-7773) if you would like to talk to a company representative.)
4. Click "Get a Quote" to find out your plan's approximate cost.
5. Complete the online application and use a credit card for payment.

Option two:
Apply with an agent

1. Call 1-866-660-4081 toll-free and ask if there's an authorized independent agent available in your area or use the "Find an Agent" tool located on **www.PremierHealthCoverage.com**.
2. The advantage of using an authorized independent agent is they can best identify your needs and assist you with locating the plan that fits those needs. Also, they can answer any questions regarding plan features and benefits.
3. The agent can assist you with evaluating which plan bests suits your needs and will help you with the application process.
4. There is no additional increase in premium when you utilize the services of one of our authorized independent agents and they are compensated directly from Aetna.

Option three:
Apply by mail

1. Fully complete the application included with this guide. Be sure to indicate which payment method you will use.
2. Use the rates included with this guide to find out how much your plan may cost.
3. Mail the completed application with your payment.

If you applied online, here's how to check your status:

1. To check your status online, visit **www.PremierHealthCoverage.com**.
2. Click the "Apply" button.
3. Enter your AARP membership information.
4. When prompted, enter your username and password to access your account.
5. Select the "My Account" link in the upper right corner to be directed to your application's status.

* To the extent permitted by law, AARP Essential Premier Health Insurance plans are medically underwritten by Aetna and you may be declined coverage in accordance with your health condition.

Special Aetna programs to help you manage your health

Aetna Rx Home Delivery®

With this optional program, you can order prescription drugs through Aetna's convenient and easy mail-order pharmacy.
To learn more, visit **www.AetnaRxHomeDelivery.com**.

Aetna Weight Management℠ program

Interested in losing weight, feeling great and saving money? If so, the Aetna Weight Management℠ discount program provides you and your eligible family members with access to discounts on diet plans, weight-loss programs, meal plans and products from several different companies.

Members can meet their specific weight-loss goals and save money on a variety of programs and plans to choose from.

Aetna's Secure Member Website

It's easy and convenient to look up health information and manage your health benefits. Any time day or night, log on to the secure member website. Check the status of claims, estimate the costs of health care services, and much more.

Informed Health® Line

Get answers to your health questions, 24 hours a day, 7 days a week, by calling a toll-free hotline staffed by Aetna's team of registered nurses. While only your doctor can diagnose, prescribe or give medical advice, the Informed Health Line nurses can provide information on more than 5,000 health topics. Contact your doctor first with any questions or concerns regarding your health care needs.

Aetna Natural Products and Services℠ program

You and eligible family members can get reduced rates on acupuncture, chiropractic care, massage therapy and diet counseling. This program also offers discounts on over-the-counter vitamins, herbal and nutritional supplements and other health-related products.

Simple Steps to Better Health Are just a Few Clicks Away

Quit smoking … drop a few pounds … deal with stress … start eating better. Do you know you need to start making healthier choices but you're not sure where to start? Aetna's Simple Steps To A Healthier Life® (Simple Steps) program is a free, customized tool designed to help you make lasting, lifelong health changes—in ways that work for you. The Simple Steps tool provides valuable online wellness coaching programs that are included with your health insurance plan, so they won't cost you a penny. You'll learn realistic steps to fit healthy habits into your busy daily routine—at your own pace. Simple Steps can help you reach a wide variety of health goals.

Neither AARP nor Aetna endorses any vendor, product or service associated with these programs.

It is not necessary to be a member of an AARP plan to access the program participating providers. The information provided by the Simple Steps To A Healthier Life program is not meant to be either a recommendation for medical treatment or a diagnosis of medical condition. Participants should consult their health care provider for the advice and care appropriate for their specific medical needs. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional.

Things to know before you apply

To qualify for an AARP® Essential Premier Health Insurance plan, you must be:

- Between the ages of 50 and 64-3/4 (if you are applying as a couple, both you and your spouse or domestic partner must be under 64-3/4), and
- Under age 26 for eligible dependent,* and
- A legal resident in a state with products offered by these plans, and
- A legal U.S. resident for at least 6 continuous months, and
- An AARP member. However, you do not need to be a member to get a quote.

Your coverage

Your coverage will remain in effect as long as you pay the required premiums on time, and as long as you maintain AARP membership eligibility. Your coverage will end, for example, if you:

- Do not pay premiums on time, or
- Do not meet residency requirements, or any other eligibility requirements noted above, or
- Have or obtain similar coverage (duplicate coverage) from another insurance company, or
- Become ineligible for other reasons permitted by law. For more information, please see the disclosure section of this brochure.

Medical underwriting

- AARP Essential Premier Health Insurance plans are not guaranteed issue plans and to the extent permitted by law, require a review of your health history (called "medical underwriting"). You may be declined coverage in accordance with your health condition. Children under the age of 19 cannot be declined coverage for pre-existing conditions.
- If declined coverage you may be federally eligible under the Health Insurance Portability and Accountability Act (HIPAA) or a special guaranteed issue plan under your state's laws and regulations.
- Applicants, enrolling spouses or domestic partners and dependents are subject to medical underwriting to determine eligibility and appropriate rate levels.
- Aetna offers various rate levels based on the known health and medical risk factors of each applicant.

Rate levels and enrollment

After processing of your application, you may be:

- Enrolled in your selected plan at the lowest rate available (known as the standard premium charge)
- Enrolled in your selected plan at a higher premium
- Declined coverage (except for dependents under age 19)

Duplicate coverage

If you currently have major medical coverage through another insurer, you must agree to discontinue that coverage before or on the effective date of your AARP Essential Premier Health Insurance Plan. **Do not cancel your current insurance until you are notified you have been accepted for coverage.**

Pre-existing conditions

For Applicants 19 and older:

- During the first 12 months after your effective date of coverage, no coverage will be provided for treatment of a pre-existing condition unless you have prior creditable coverage.
- A "pre-existing condition" is any physical or mental condition you've been diagnosed or treated for during the "lookback period" before the date your coverage begins. "Prior creditable coverage" is a person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPPA), and in any applicable State law.
- You are considered to have prior creditable coverage if the difference between the prior coverage termination date and signature date on you application is NOT greater than 63 days.
- Prior creditable coverage does not guarantee acceptance into the AARP® Essential Premier Health Insurance plan, insured by Aetna.
- If you have prior creditable coverage within 63 days immediately before the signature date on your application, then the pre-existing conditions exclusion of the plan will be waived.
- See the Words To Know section of this booklet for more information on the lookback period and creditable coverage.

10-day right to review

- Do not cancel your current insurance until you're notified you've been accepted for coverage.
- Aetna will review your application to determine if you meet underwriting requirements. If you're denied, you will be notified by mail. If approved, you'll be sent an AARP Essential Premier Health Insurance contract and ID card.
- If, after reviewing the contract, you are not satisfied for any reason, simply return the contract to us within 10 days of your receipt. We will refund any premium you have paid, less the cost of any services paid on behalf of you or any covered dependent.
- An eligible dependent is defined as under age 28 (or higher if allowed by state law) and dependent upon an AARP member for support and maintenance and is one of the following natural child, stepchild, legally adopted child, child planed for adoption, child for who legal guardianship has been awarded to the AARP member, or relative of the AARP member by blood marriage.

Have questions or want a quote?

Have questions or want a quote? Call a representative toll-free at 1-866-660-4081 (TTY: 1-800-232-7773). Ask about authorized independent insurance agents in your area or visit www.PremierHealthCoverage.com to Find an Agent in your area.

* An eligible dependent is defined as under age 28 (**or higher if allowed by state law**) and dependent upon an AARP member for support and maintenance and is one of the following: natural child, stepchild, legally adopted child, child placed for adoption, child for whom legal guardianship has been awarded to the AARP member, or relative of the AARP member by blood or marriage.

Limitations and exclusions

Have questions or want a quote?

Have questions or want a quote? Call a representative toll-free at 1-866-660-4081 (TTY: 1-800-232-7773). Ask about authorized independent insurance agents in your area or visit www.PremierHealthCoverage.com to Find an Agent in your area.

The health insurance plans in this guide do not cover all health care expenses, and they include exclusions and limitations. Refer to plan documents to determine which health care services are covered and to what extent.

Services and supplies that are generally NOT covered include, but are not limited to:

- Surgery or related services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma or congenital or developmental anomalies.
- Private duty nursing.
- Personal care services and home care services not stated in the plan description.
- Non-replacement fees for blood and blood products.
- Dental work or treatment, unless otherwise specified in covered services, including hospital or professional care in connection with:
  - The operation or treatment for fitting or wearing of dentures
  - Orthodontic care
  - Dental implants
  - Experimental services

- Immunizations related to foreign travel.
- The purchase, examination or fitting of hearing aids and supplies, and tinnitus maskers, unless included as a covered benefit.
- Arch support, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports, or exams for their prescription or fitting, unless these services are determined to be medically necessary.
- Inpatient admissions primarily for physical therapy unless authorized by the plan.
- Charges in connection with pregnancy care, other than for pregnancy complications.
- Treatment of sexual dysfunction not related to organic disease.
- Services to reverse a voluntary sterilization.
- In vitro fertilization, ovum transplants and gamete intrafallopian tube transfer, or cryogenic or other preservation techniques used in these or similar procedures.
- Practitioner, hospital or clinical services related to the procedure commonly referred to as "Lasik Eye Surgery," including radial keratomy, myopi keratomileusis, and surgery that involved corneal tissue for the purpose of altering, modifying or correcting myopia, hyperopia or stigmatic error.
- Nonmedical ancillary services such as vocational rehabilitation, employment, counseling, or educational therapy.
- Services that are not medically necessary.
- Medical expenses for a pre-existing condition, for the first 12 months after the member's effective date. Look-back period for determining a pre-existing condition (conditions for which diagnosis, care or treatment was recommended or received) is 6 months prior to the effective date of coverage. If the applicant had prior creditable coverage within 63 days immediately before the signature of the application, then the pre-existing conditions exclusion of the plan will be waived. See the "Words To Know" section of this booklet for more information on pre-existing conditions and prior creditable coverage.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regiments and supplements, appetite suppressants and other medication: food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Words to know

Here are definitions of some commonly used health insurance terms. They may help you make more informed decisions about your health care coverage. (For more terms, please visit www.planforyourhealth.com.)

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)
Some employers are mandated by law to offer employees who terminate employment the option to continue their health coverage for up to 18 months. The employee pays the full premium, up to 102% of the employer's cost (the extra 2% is the administration fee).

COBRA can cover ALL members of your family from the date of your termination of employment, so if your spouse or domestic partner has a pre-existing condition that a new, cheaper policy might not cover, you can elect to keep COBRA for him or her. If you're considering COBRA, be sure to get more information from your employer.

Copay
After you've met your annual deductible amount, this is the fixed dollar amount you pay for a specific medical service, product or prescription drug. For example, a plan might state your copay for a doctor office visit is $25, while the insurance company pays the rest of the cost.

Coinsurance
Similar to a copayment, with one exception: the amount you pay for covered medical services is expressed as a percentage instead of a dollar amount. So, for example, if your plan's hospitalization coinsurance is 20%, it means you'll pay 20% of total hospital fees while the insurance company pays the other 80%.

Deductible
The amount you pay for covered services in a specified time period before the plan will pay benefits. For a plan requiring a $1,000 annual deductible, for instance, you'll pay $1,000 out of your pocket for medical expenses each year before the insurance company starts paying for anything. (Typically, the higher your deductible, the lower your monthly premium).

HSA (Health Savings Account)
A tax-advantaged financial account, with various restrictions, that helps cover current and future medical expenses.

Look-Back Period
When you enroll for health insurance, you must report any medical conditions for which you have been diagnosed or treated during the "look-back" period. For example, if a health plan has a 6 month look-back period, you have to report conditions you had treated in the last 6 months. Based on your answers, you'll either be accepted, denied or accepted with a pre-existing condition "waiting period" — the time you must wait before your pre-existing conditions can be covered.

Out-of-Pocket Costs
Premiums, copayments, deductibles, coinsurance or other fees you're required to pay outside of your health benefits plan.

Out-of-Pocket Maximums
After you meet your annual deductible, this is the most coinsurance dollars you'll have to pay in a single year.

Pre-existing Conditions
Any physical or mental condition you've been diagnosed or treated for before the date your health coverage begins.

Premium
The fee you pay, usually monthly, to an insurance company to be covered by a health insurance plan.

Primary Care Physician
A doctor who provides, coordinates or arranges for care to patients, and takes continuing responsibility for providing a patient's care.

Prior Creditable Coverage
A person's prior medical coverage, as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This coverage includes: health coverage issued on a group or individual basis; Medicare; Medicaid; health care for members of the uniformed services; a program of the Indian Health Service; a state health benefits risk pool; the Federal Employees' Health Benefit Plan (FEHBP); a public health plan (any plan established by a State, the government of the United States, or any subdivision of a State or of the government of the United States, or a foreign country); any health benefit plan under Section 5(e) of the Peace Corps Act; and the State Children's Health Insurance Program (SCHIP).

Referrals
A doctor's and/or health plan's recommendation for you to receive care from a different physician, specialist or facility.

Specialist
A doctor who has completed an approved residency, passed an examination given by a medical specialty board, and has been certified as a specialist in a medical area.

Underwriting
The process insurance companies use to evaluate the costs of insuring you and determining if you're eligible for coverage. It can involve asking medical questions or requiring health exams. If you're eligible for coverage, your rate level (and your premiums) will be based on this underwriting.

Have questions or want a quote?

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AARP® | Essential Premier Health Insurance
insured by aetna™

Aexcel® – Aetna's network of high-performing physicians

Specialists with the Aexcel® designation meet standards for clinical performance and efficiency.

Get more information about your doctor before you visit.

Visit: **www.PremierHealthCoverage.com** |

The Aexcel network

Aexcel, Aetna's performance network, gives you access to some of the high-performing specialists.

Specialty doctors and doctor groups with the Aexcel designation:

- Are part of the Aetna network of health care providers
- Have met industry-accepted practices for clinical performance
- Have met Aetna's efficiency standards

You'll find other advantages, too.

As an AARP® Essential Premier Health Insurance member, when you visit one of these doctors, referrals are not needed.

Get care in 12 specialty areas.

Visit doctors and doctor groups in these 12 areas:

- Cardiology
- Cardiothoracic Surgery
- Gastroenterology
- General Surgery
- Neurology
- Neurosurgery
- Obstetrics and Gynecology
- Orthopedics
- Otolaryngology/ENT
- Plastic Surgery
- Urology
- Vascular Surgery

Consider Aexcel-designated doctors when you need specialty care.

How does Aetna choose specialists for Aexcel designation?

Aetna analyzes specialists' performance using nationally recognized standards from many groups. These include the American Heart Association, American College of Obstetricians and Gynecologists, Agency for Health Research and Quality, Society of Thoracic Surgeons, and Centers for Medicare & Medicaid Services.

Measurable standards

Items tracked:

- Hospital readmission rates after 30 days
- Rates of health complications during hospital care
- Other treatments, by specialty, shown to improve outcomes

Aetna also looks at external recognition information specific to the physicians' Aexcel specialty.

Cost of Care

Also reviewed are the costs of treating Aetna members in each of the 12 Aexcel areas of care. Aetna tries to include all costs — not just visits to the doctor's office.

Items reviewed are inpatient, outpatient, diagnostic, lab and pharmacy claims. The total costs of care from each doctor to the costs of other doctors in the same region are then compared.

The doctors who best meet the above standards are chosen to receive the Aexcel designation.

Frequently asked questions

How can I find an Aexcel-designated doctor?
AARP Essential Premier Health Insurance members can access Aetna's DocFind® online provider directory at **www.aetna.com/docfind/custom/advplans**. Aexcel-designated doctors have a blue star next to their name.

More information is available on Aetna Navigator®, your secure member website. Just log in, enter DocFind, and search for a specialist. Click on the "Provider Details" link below an Aexcel-designated specialist and then click on the "View Clinical Quality and Efficiency" tab.

You can find more information on Aexcel designation in our Understanding Aexcel brochure. It's also available online in DocFind at **www.UnderstandingAexcel.com**. Simply click on the "Learn More" section.

Do I need a referral to see an Aexcel-designated doctor?
No. AARP Essential Premier Health Insurance members do not need a referral to see an Aexcel-designated doctor.

Will I pay extra for an Aexcel-designated specialist?
No. In fact, by visiting an Aexcel-designated specialist, your benefits are considered in-network. Plus, doctors with the Aexcel designation have been shown to work efficiently within the health care system. That is good news for your health.

What if a doctor is part of a group?
If a doctor is part of a group, we evaluate the entire group. In this case, performance-measurement results of other doctors in the group affect each individual doctor's evaluation.

Specialists are regularly reviewed for the Aexcel designation. Please check your doctor's status before making an appointment.

Aexcel designation is only a guide for choosing a physician. Members should confer with their existing physicians before making a decision. Designations have risk of error and should not be the sole basis for selecting a doctor. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations, and conditions of coverage.

AARP® | Essential Premier Health Insurance
insured by aetna℠

Important disclosure information

Disclosures

This health care coverage may not cover all your health care expenses. Read your coverage documents carefully to determine which health care services are covered. To contact the plan if you are a member, call the number on your ID card; all others, call 1-866-660-4081.

Plan Benefits

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

Member Cost Sharing

Cost sharing refers to the portion of medical services that you pay out of your own pocket.

Refer to your plan documents to see which of the of the following cost-sharing provisions apply to your plan:

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

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

Your Primary Care Physician

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

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

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

Referral Policy

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

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

The following points are important to remember regarding referrals:

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

Direct Access Ob/Gyn Program

This program allows female members to visit without a referral any participating obstetrician or gynecologist for a routine breast exam, mammogram and a Pap smear, and for obstetric or gynecologic problems. Obstetricians and gynecologists may also refer a woman directly to other participating providers for covered obstetric or gynecologic services. All health plan preauthorization and coordination requirements also apply. If your Ob/Gyn is part of an Independent Practice Association (IPA), a Physician Medical Group (PMG), an Integrated Delivery System (IDS) or a similar organization, your care must be coordinated through the IPA, the PMG or similar organization and that organization may have different referral policies.

Disclosures (Continued)

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

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

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

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

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

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

Advance Directives

There are three types of advance directives:

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

You can create an advance directive in several ways:

- Get an advance medical directive form from a health care professional. Certain laws require health care facilities that receive Medicare and Medicaid funds to ask all patients at the time they are admitted if they have an advance directive. You don't need an advance directive to receive care. But we are required by law to give you the chance to create one.
- Ask for an advance directive form at state or local offices on aging, bar associations, legal service programs, or your local health department.
- Work with a lawyer to write an advance directive.
- Create an advance directive using computer software designed for this purpose.
- If you are not satisfied with the way Aetna handles advance directives, you can file a complaint with your Medicare State Certification Agency. Visit **www.medicare.gov** for information on specific state agencies or call 1-800-MEDICARE (1-800-633-4227) (TTY/TDD: 1-877-486-2048).

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

Transplants and Other Complex Conditions

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

Note: There are exceptions depending on state requirements.

Emergency Care

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

- Call the local emergency hotline (ex. 911) or go to the nearest emergency facility. If a delay would not be detrimental to your health, call your doctor or PCP. Notify your doctor or PCP as soon as possible after receiving treatment.
- If you are admitted to an inpatient facility, you or a family member or friend on your behalf should notify your doctor, PCP or Aetna as soon as possible.

Disclosures (Continued)

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

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

After-Hours Care
You may call your provider's office 24 hours a day, 7 days a week if you have medical questions or concerns. You may also consider visiting participating Urgent Care facilities. See your plan documents for cost-sharing provisions for urgent care services.

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

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

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

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

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

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

Updates to the Drug Formulary

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

Disclosures (Continued)

Behavioral Health Network
Behavioral health care services are managed by Aetna. As a result, Aetna is responsible for making initial coverage determinations and coordinating referrals to the Aetna provider network. As with other coverage determinations, you may appeal adverse behavioral health care coverage determinations in accordance with the terms of your health plan.

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

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

- Call the toll-free Behavioral Health number (where applicable) listed on your ID card or, if no number is listed, call the Member Services number listed on your ID card for the appropriate information.
- Where required by your plan, call your PCP for a referral to the designated behavioral health provider group.
- When applicable, an employee assistance or student assistance professional may refer you to your designated behavioral health provider group. You can access most outpatient therapy services without a referral or preauthorization. However, you should first consult Member Services to confirm that any such outpatient therapy services do not require a referral or preauthorization.

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

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

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

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

How Aetna Pays Out-of-Network Providers

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

Prevailing Charge Plans

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

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

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

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

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

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

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

Disclosures (Continued)

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

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

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

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

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

How Aetna Pays for Out-of-Network Behavioral Health Benefits
We negotiate rates with psychiatrists, psychologists, counselors and other appropriately licensed and credentialed behavioral health care providers to help you save money. We refer to these providers as being "in our network."

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

- Study published medical research and scientific evidence on the safety and effectiveness of medical technologies.
- Consider position statements and clinical practice guidelines from medical and government groups, including the federal Agency for Health Care Research and Quality.
- Seek input from relevant specialists and experts in the technology.
- Determine whether the technologies are experimental or investigational. You can find out more on new tests and treatments in our Clinical Policy Bulletins. See Clinical Policy Bulletins on the next page for more information.

Medically Necessary

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

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

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

Clinical Policy Bulletins

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

Aetna CPBs do not constitute medical advice. Treating providers are solely responsible for medical advice and for your treatment. You should discuss any CPB related to your coverage or condition with your treating provider. While Aetna CPBs are developed to assist in administering plan benefits, they do not constitute a description of plan benefits. Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. You and your providers will need to consult the benefit plan to determine if there are any exclusions or other benefit limitations applicable to this service or supply.

CPBs are regularly updated and are therefore subject to change. Aetna CPBs are available at **www.aetna.com** under "Members" and then "Health Coverage Information." If you do not have Internet access, please contact Member Services at the toll-free number on your ID card for information about specific Clinical Policy Bulletins.

Disclosures (Continued)

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

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

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

Where such use is appropriate, our Utilization Review/Patient Management staff uses nationally recognized guidelines and resources, such as The Milliman Care Guidelines® to guide the precertification, concurrent review and retrospective review processes. To the extent certain Utilization Review/Patient Management functions are delegated to IDSs, IPAs or other provider groups ("Delegates"), such Delegates utilize criteria that they deem appropriate. Utilization Review/Patient Management policies may be modified to comply with applicable state law.

Only medical professionals make decisions denying coverage for services for reasons of medical necessity. Coverage denial letters for such decisions delineate any unmet criteria, standards and guidelines, and inform the provider and you of the appeal process. For more information concerning utilization management, you may request a free copy of the criteria we use to make specific coverage decisions by contacting Member Services.

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

Concurrent Review
Concurrent review is a review conducted while a patient is confined on an inpatient basis. The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members receiving inpatient services. All inpatient services extending beyond the initial certification period require concurrent review.

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

Retrospective Record Review

Retrospective review is a review conducted after the patient has been discharged from the hospital or facility. The purpose of retrospective review is to analyze potential quality and utilization issues, initiate appropriate follow-up action based on quality or utilization issues, and review all appeals of inpatient concurrent review decisions for coverage of health care services. Our effort to manage the services provided to you includes the retrospective review of claims submitted for payment, and of medical records submitted for potential quality and utilization concerns.

Complaints, Appeals and External Review

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

Filing a Complaint or Appeal

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

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

About Coverage Decisions

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

External Review

We established an external review process to give you the opportunity of requesting an objective and timely independent review of certain coverage denials. Once the applicable internal appeal process has been exhausted, you may request an external review of the decision for the coverage denial if: (a) you would be financially responsible for the cost of services; (b) the amount of the service(s) is more than $500, and (c) is based on lack of medical necessity or on the experimental or investigational nature of the proposed service or supply. Standards may vary by state, and several states have external review processes that may apply to your plan.

If a request meets the requirement for an external review, an Independent Review Organization (IRO) will assign the case to an external physician reviewer with appropriate expertise for an independent decision in the area in question. After all necessary information is submitted, an external review generally will be decided within 30 calendar days of the request. Expedited reviews are available when your physician certifies that a delay in service would jeopardize your health.

Disclosures (Continued)

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

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

Member Rights & Responsibilities

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

Member Services

To file a complaint or an appeal, for additional information regarding copayments and other charges, information regarding benefits, to obtain copies of plan documents, information regarding how to file a claim or for any other question, you can contact Member Services at the toll-free number on your ID card, or e-mail us from your secure Aetna Navigator member website at **www.aetna.com**. Click on "Contact Us" after you log on.

Spanish-speaking hotline — **1-800-533-6615**

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

Interpreter/Hearing Impaired

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

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

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

Quality Management Programs

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

Privacy Notice

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

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

Disclosures (Continued)

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

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

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

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

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

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

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

Health Insurance Portability and Accountability Act

If you are enrolled in a group health plan, the following information is provided to inform you of certain provisions contained in the group health plan, and related procedures that may be utilized by you in accordance with federal law.

Special Enrollment Rights

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

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

Request for Certificate of Creditable Coverage

If you are a member of an insured plan sponsor or a member of a self-insured plan sponsor who have contracted with us to provide Certificates of Prior Health Coverage, you have the option to request a certificate. This applies to you if you are a terminated member, or are a member who is currently active but would like a certificate to verify your status. As a terminated member, you can request a certificate for up to 24 months following the date of your termination. As an active member, you can request a certificate at any time. To request a Certificate of Prior Health Coverage, please contact Member Services at the telephone number listed on your ID card.

Notice Regarding Women's Health and Cancer Rights Act

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

(1) reconstruction of the breast on which a mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; (3) prostheses; and (4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy. If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

Disclosures (Continued)

Where can I find tips and tools for staying healthy?

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

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

Health benefits and health insurance plans are underwritten or administered by Aetna Life Insurance Company (Aetna).

Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Information subject to change.

Aetna is committed to Accreditation by the National Committee for Quality Assurance (NCQA) as a means of demonstrating a commitment to continuous quality improvement and meeting customer expectations. A complete listing of health plans and their NCQA accreditation status can be found on the NCQA website located at **www.ncqa.org/tabid/142/Default.aspx**.

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

Health care providers who have been duly recognized by the NCQA Recognition Programs are annotated in the Physician Directory. Providers, in all settings, achieve recognition by submitting data that demonstrates they are providing quality care. The program constantly assesses key measures that were carefully defined and tested for their relationship to improved care; therefore, NCQA provider recognition is subject to change. For up-to-date information, please visit our DocFind® directory at **www.aetna.com** or, if applicable, visit the NCQA's new top-level recognition listing at **www.ncqa.org/tabid/58/Default.aspx**. If you do not have access to the Internet and would like a printed physician directory, please contact Member Services at the toll-free number shown on your Aetna ID card.

Have questions or want a quote?

Call a representative toll-free at 1-866-660-4081 (TTY: 1-800-232-7773). Ask about authorized independent insurance agents in your area.

This material is for information only. Health insurance plans contain exclusions and limitations.

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. 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 receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional.

Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc. that operates through mail order.

Aetna pays royalty fees to AARP for the use of its intellectual property. These fees are used for the general purposes of AARP.

AARP and it's affiliates are not insurers.

AARP does not employ or endorse agents, producers or brokers. (An agent may call you.)

If you need this material translated into another language, please call 1-866-660-4081 (TTY: 1-800-232-7773).

Si usted necesita este documento en otro idioma, por favor llame al 1-866-660-4081.

Information is believed to be accurate as of the production date; however, it is subject to change.

AARP established the AARP Insurance Plan, a trust, to hold the master group insurance policies. The Essential Premier Health Insurance Plan is insured by Aetna, not by AARP or its affiliates. Please contact Aetna if you have questions about your policy, including any limitations and exclusions.

Premiums are collected from you by the Trust. These premiums are paid to the insurance company for your insurance coverage, a percentage is used to pay expenses, benefitting the insureds, and incurred by the Trust in connection with the insurance programs. At the direction of Aetna, a portion of the premium is paid as a royalty to AARP and used for the general purposes of AARP. Income earned from the investment of premiums while on deposit with the Trust is paid to AARP and used for the general purposes of AARP.

Participants are issued certificates of insurance by Aetna under the master group insurance policy. The benefits of participating in an insurance program carrying the AARP name are solely the right to receive the insurance coverage and ancillary services provided by the program.

AARP® | Essential Premier Health Insurance insured by aetna™

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