OPEN CHOICE® PPO
Consumer Disclosure Information

For The State Of New York

All Members

Your plan of benefits will be determined by your School and underwritten by Aetna Insurance Company of Connecticut (Aetna) for schools located in New York City and by Aetna Life Insurance Company (Aetna) for all other schools. Aetna is located at 151 Farmington Avenue, Hartford, Connecticut, 06156. Your Plan Administrator is Chickering Claims Administrators, Inc., 1010 Commonwealth Avenue, Boston, MA 02215-1201. The benefits and main points of the Master Policy for persons covered under your School's plan of benefits will be set forth in the Student Health Insurance Plan Brochure which will be provided to you at a later date. In case of conflict between the Master Policy and the Plan Brochure and this document, the Master Policy will govern the payment of benefits.

Member Copayments and Deductibles

The plans listed above may contain some or all of the following features:

- Copayments – These are fees that you must pay for some covered medical expenses.
- 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 – This is the amount of inpatient hospital expenses you pay for each hospital confinement.

- Emergency Room Deductible – A separate hospital emergency room deductible applies to each visit by a person in 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 copayment and deductible listed above will be determined by your School and described in your plan documents.

Patient Management Program

Aetna evaluates and determines the appropriateness of medical care resources utilized by our members. To accomplish these goals, Aetna has developed a comprehensive Patient Management Program. The population demographics of the membership and the program's results are reviewed to determine the need for changes. Regional Medical Directors in concert with local market Medical Directors review this information to initiate new program development or enhancement to current programs. The Patient Management Program is reviewed annually.

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

- ***Precertification***
  You must obtain precertification for certain types of care to avoid a reduction in benefits paid for that care.

  To request precertification, you must call the number shown on your ID card. Such precertification must be obtained before care is received, or in the case of an emergency admission, procedure or treatment, within 1 business day after the start of a confinement as a full-time inpatient or the performance of the procedure or treatment, or as soon as reasonably possible.

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

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

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

Emergency Care

An "emergency condition" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the

absence of immediate medical attention to result in (A) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; or (B) serious impairment to such person's bodily functions; (C) serious dysfunction of any bodily organ or part of such person; or (D) serious disfigurement of such person.

Provider Reimbursement

Participating providers are reimbursed on a discounted fee-for-service basis. Where the member is responsible for a coinsurance payment based on a percentage of the bill, the member's obligation is to be determined on the basis of the charges established by contract, if any, rather than on the basis of the provider's billed charges.

Non-participating providers, providing covered services, are compensated on a fee-for-service basis.

Aetna Pharmacy Management negotiates discounts from independent pharmacies and chain pharmacies that participate in the Aetna network. The reimbursement formula is based on Average Wholesale Price (AWP) less a negotiated discount, plus a dispensing fee. The dispensing fee is a contractual fee negotiated between Aetna Pharmacy Management and the network pharmacy. With Internet access, you can conduct an on-line search for participating pharmacies through DocFind®, which is available on our website at ***www.aetna.com*** A paper directory is also available to members.

Any charge for a service or supply furnished by a participating provider in excess of such provider's negotiated charge for that service or supply will not be a covered expense under the plan. In no event will you or your eligible

dependents be expected to pay any such excess charge. It will be the responsibility of Aetna and the participating provider to resolve the amount deemed to be excess.

Confidentiality

Aetna protects the privacy of confidential member medical information. We require that participating providers keep member information confidential in accordance with applicable laws. Furthermore, you have the right to access your medical records from participating providers, at any time.

Aetna (including its affiliates and authorized agents, collectively "Aetna") and participating providers require access to member medical information for a number of important and appropriate purposes, including claims payment, fraud prevention, coordination of care, data collection, performance measurement, fulfilling state and federal requirements, quality management, utilization review, research and accreditation activities, preventive health, early detection and disease management programs. Accordingly, for these purposes, members authorize the sharing of member medical information about themselves and their dependents between Aetna and participating providers and health delivery systems.

Complaint and Appeals Procedure

Our complaints and appeals process is designed to address member coverage issues, complaints and problems. If you have a coverage issue or other problem, call the Customer Service toll-free number on your ID card.

A representative will address your concern. If you are dissatisfied with the outcome of your initial contact, you may appeal the decision. Your appeal will be decided in accordance with the procedures applicable to your plan.

You may also submit your request, in writing, along with all pertinent correspondence, to:
Chickering Claims Administrators, Inc.
P.O. Box 15717
Boston, MA 02215-0014

External Appeal (effective July 1, 1999)

You may file an application for an external appeal by a state approved external appeal agent if you have received a denial of coverage based on medical necessity or because the service is experimental and/or investigational.

To be eligible for an external appeal, you must have received a final adverse determination as a result of the plan's first-level utilization review (UR) appeal process or both you and the plan must have jointly agreed to waive the UR appeal process.

You may obtain an external appeal application from:

- the New York State Department of Insurance at (800) 400-8882, or its website (***www.ins.state.ny.us***),
- the New York State Department of Health at (518) 486-6074, or its website (***www.health.state.ny.us***), or
- our Customer Service department at the toll-free number shown on your ID card.

The application will provide clear instructions for completion. To file an external appeal, you must include $50.00 (fifty dollars) with the application. This money will be refunded if the external appeal is decided in your favor. You may obtain a waiver of this fee if you meet the plan's criteria for a hardship exemption.

The application for external appeal must be made within 45 days of your receipt of the notice of final adverse determination as a result of the plan's first-level appeal process, or within 45 days of when you and the plan jointly agree to waive the internal appeal process. Additional internal plan appeals may be available to you which are optional. However, regardless of whether you participate in additional internal plan appeals, an application for external appeal must be filed with the New York State Department of Insurance within 45 days from your receipt of the notice of final adverse determination from a first level internal plan appeal to be eligible to be reviewed by an external appeal agent.

You will lose your right to an external appeal if you do not file an application for an external appeal within 45 days from your receipt of the final adverse determination from the first level internal plan appeal.

The application will instruct you to send it to the New York State Department of Insurance.
You (and your doctors) must release all pertinent medical information concerning your medical condition and request for services. An independent external appeal agent approved by the state will review your request to determine if the denied service is medically necessary and should be covered by the plan. All external appeals are conducted by clinical peer reviewers. The agent's decision is final and binding on both you and the plan.

An external appeal agent must decide a standard appeal within 30 days of receiving your application for external appeal from the state. Five (5) additional business days may be added if the agent needs additional information. If the agent determines that the information submitted to

it is materially different from that considered by the plan, the plan will have three (3) additional business days to reconsider or affirm its decision. You and the plan will be notified within two (2) business days of the agent's decision.

You may request an expedited appeal if your doctor can attest that a delay in providing the recommended treatment would pose an imminent or serious threat to your health. The external appeal agent will make a decision within three days for expedited appeals. Every reasonable effort will be made to notify you and the plan of the decision by telephone or fax immediately. This will be followed immediately by a written notice.

Notice to Enrollees

While the directory (available upon request) is believed to be accurate as of the print date, it is subject to change without notice. Consult Aetna's online provider directory on our website (***www.aetna.com/docfind***) for the most current provider listings. Participating providers are independent contractors in private practice and are neither employees nor agents of Aetna, the School, or Chickering Claims Administrators, Inc. The availability of any particular provider cannot be guaranteed for referred or in-network benefits, and provider network composition is subject to change without notice. Certain primary care physicians may be affiliated with an Independent Practice Association (IPA), a Physician Medical Group (PMG), an integrated delivery system or one of other provider groups.

Not every provider listed in the directory will be accepting new patients. Although Aetna has identified providers who were not accepting patients as known to Aetna at the time the provider directory was created, the status of a provider's practice may have changed. For the most current information, please contact the selected physician or Customer Service at the toll-free number on your ID card.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan or program benefits and does not constitute a contract or any part of one. For a complete description of the benefits available to you, including procedures, exclusions and limitations, please request a copy of your Plan Brochure. All the terms and conditions of your plan or program are subject to applicable laws, regulations, and policies. The availability of a plan or program may vary by geographic service area, and not all plans or programs are available in all areas. Certain services, including but not limited to non-emergency inpatient hospital care, require precertification. All benefits are subject to coordination of benefits. In case of a conflict between your plan documents and this information, the plan documents will govern.

In the event of a problem with coverage, members should contact Customer Service at the toll-free number on their ID cards for information on how to utilize the complaint and appeal procedure when appropriate.

All member care and related decisions are the sole responsibility of participating providers. Aetna does not provide health care services and, therefore, cannot guarantee any results or outcomes.

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