Aetna Life Insurance Company (Aetna) offers large group PPO health benefit plans in the state of Arkansas (along with access through bordering states) through the Open Access Network of participating providers and facilities. This network access plan is required pursuant to Arkansas Final Rule 054.00.14-002 - Rule 106: Network Adequacy Requirements for Health Benefit Plans.

At Aetna, we work every day to ensure the power of health is in our customer's hands. We strive to see the world from the customer's perspective and provide convenient tools and resources that fit their life. We provide the support needed, when it is needed, so that our members can make confident choices and live a healthier life.

Aetna has established certain policies and procedures in order to ensure access is available to our members through the Open Access Network. A brief description of some of these policies and procedures are provided in the following sections of this Network Access Plan. Unless stated otherwise, the reference to providers in this Network Access Plan includes facilities. This Network Access Plan also uses the term "member" and "enrollee' interchangeably.

1. Aetna's Network Description

Aetna members enrolled in the large group PPO benefit plans access services through the Open Access Network. The Open Access Network is accessible in all counties in AR including bordering counties in neighboring states: MS; TN; TX; OK; MO; and LA.

Members pay less out-of-pocket when they use providers and hospitals in our Open Access Network. Our provider networks prioritize quality and efficiency to improve health care experience and make it easy for individuals to get the care they need. The Open Access Network is a comprehensive provider network comprised of doctors, hospitals, allied health professionals, and other health care facilities located throughout the state. The network also includes reciprocity for coverage of contracted providers throughout the nation, should the member need care while traveling. Aetna negotiates discounted rates for covered health care services. In-network providers and hospitals won't bill Aetna members for costs above our negotiated rates for covered services.

Coverage for emergent out-of-network services is identical to in-network benefits. Additionally, the PPO benefit plan provides coverage for non-emergency out-of-network services the member elects to choose, at a reduced benefit level. The Open Access Network is not tiered – there is a single level of in-network benefit coverage and a single level of out-of-network benefit coverage.

2. Aetna's procedures for making referrals within and outside its network and for notifying enrollees and potential enrollees regarding availability of network and out-of-network providers.

Aetna maintains a broad network of participating primary care physicians (PCPs), specialists and facilities that members can access. Referrals to participating providers are not required for this plan, for either medical or behavioral health benefits. Members have open access to choosing and accessing participating primary care, specialist, and behavioral health providers. Should a member request or require services from a non-participating provider at the in-network or highest benefit level, pre-certification would be required.

Nurses and behavioral health (BH) clinicians review coverage requests for in-network benefits/the member's highest benefit level for services by a non-participating provider or a provider/facility not associated with the member's highest benefit level under the clinical direction of a physician Medical Director or psychologist.

Precertification for non-participating provider services at an in-network level of benefits includes review by a Medical Director or consultant psychiatrist/psychologist; and a determination that the requested service is not available within the market defined access standard. State mandates for minimum and/or maximum requirements supersede the market defined access standards.

Staff contacts up to three (3) unaffiliated participating providers to locate one (1) provider within the market access standard (as applicable) who is accepting new patients and who can treat the member's condition.

Elective care by a non-participating provider or a provider/facility not associated with the member's highest benefit level is approved at an in-network benefits level/the highest level of benefits only if the member requires a unique, highly specialized service that is not otherwise available within the health plan network/designated plan network. The clinical staff considers continuity of care issues for members with complex medical and BH problems when reviewing such requests. A physician Medical Director or psychologist is responsible for all clinical coverage denial decisions. The member and the requesting provider receive a coverage denial determination letter when the Medical Director or psychologist does not approve the coverage request. The name and telephone number of a confirmed alternative participating provider who can evaluate and treat the member's condition is included in the coverage denial determination letter when applicable.

Staff conducts outreach to identify whether alternative network providers can evaluate and treat the member's condition. Outreach may include but is not limited to:

- A direct conversation with alternative network providers/office staff confirming that the provider can evaluate and treat the member's condition;
- A direct conversation with the PCP or referring provider to include an explanation that coverage would be available for a second opinion with an alternative network provider;
- A direct conversation with the non-participating provider to include an explanation of the proposed treatment;
- Sending clinical information to the alternative network provider for review (absent any member identifying information);
- Having the alternative network provider speak directly to the non-participating provider.

Payment for non-participating provider services at the in-network level of benefits level requires approval through the precertification process prior to the date of service. If pre-certification is approved, the member will be able to access services from the non-participating provider at no greater cost to the member than if the services were obtained from participating providers.

Elements considered during the in-network benefit review process for non-participating provider services include, but are not limited to:

- The information from the precertification process with the supporting rationale for the request;

- A review of plan documents to determine whether the requested service is a covered benefit;
- A determination as to whether the service is medically necessary based upon approved criteria/guidelines, is unique or highly specialized, is not otherwise available from a participating provider or the available participating provider falls outside of designated market access standards.

The following considerations are assessed as part of the coverage determination process when reviewing a request for in-network benefits for non-emergency services by a non-participating provider:

- The member's stability for travel;
- A determination whether a participating provider is available within the access standard or in geographic proximity to the member's service area;
- Any applicable state or federal requirements;
- Continuity of care;
- Coordination of follow-up services by participating providers; and,
- Transfer to participating providers within the service area as soon as clinically feasible.

3. Aetna's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in its health benefit plans.

Geographic adequacy standards are established and monitored on a routine basis by the National Quality Oversight Committee in collaboration with local market compliance and network. The health plan utilizes these standards to assess network adequacy. These standards are based on federal network adequacy standards applicable to Medicare Advantage plans and adjusted to reflect the age demographics of the enrollees in the plan. Geographic adequacy is evaluated quarterly for members in this plan. Geo-access reports are summarized and shared with network and plan leadership, including behavioral health team leadership. Results of the availability assessments are used in developing and implementing market contracting plans.

In addition to the geographic standards, the Aetna Quality Oversight Committee (NQOC) establishes standards for access to care and service for meeting the healthcare needs of current membership. Identified opportunities for quality improvement actions are prioritized and actions implemented to improve performance. Compliance with the accessibility standards is measured using valid methodology and analyzed on an annual basis utilizing the following mechanisms:

- Primary Care Physician and Specialty Care Physician; OB/GYN (high volume) and Oncology (high impact) access standards are established for regular/routine care appointments, urgent care appointments and for after-hours care. Access is monitored through several avenues: member complaints, telephonic provider surveys or member experience survey data (CAHPS 5.0H Adult Commercial Consumer Satisfaction Survey).

- Member Services telephone access is monitored using statistical data regarding call abandonment rate, average speed of answer and total service factor. Member complaint data is tracked and trended.

Compliance with the Behavioral Health (BH) accessibility standards is measured using valid methodology and analyzed on an annual basis utilizing the following mechanisms:

- Behavioral Health Provider access standards are established for regular/routine care appointments, urgent care appointments and for after-hours care. Access is monitored through several avenues: member complaints, BH member experience survey data, BH provider experience survey data and/or telephonic surveys.

- Member Services telephone access is monitored using statistical data regarding call abandonment rate, average speed of answer and total service factor. Member complaint data is tracked and trended.

- Aetna annually review its policies and procedures, including criteria for participation such as credentialing and physical office standards, as well as network adequacy requirements such as geographic accessibility and appointment availability. This review is undertaken to ensure our standards remain compliant with federal and state requirements, as well as up to date with accreditation criteria, and competitive trends.

4. Aetna's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities.

Aetna takes an aggressive approach to addressing the needs of members with diverse cultural or ethnic backgrounds through a coordinated, multi-dimensional program comprised of a variety of research, education, customer service, data collection, and general awareness initiatives. We have designed and implemented programs which have been successful in improving clinical and quality outcomes for minority members.

Experts agree that one of the most important tasks a health insurer can implement to reduce health care disparities is to know the race and ethnicity of each member. Evidence shows that different racial and ethnic groups are at higher risk for certain diseases and conditions. This information helps us create more culturally focused disease management and wellness programs. It also allows us to identify disparities and pilot new approaches to reduce disparities. To monitor cultural and linguistic needs to ensure processes are in place to serve a diverse membership, both analyses are used to identify overall population needs. Individual member needs are addressed through various resources, such as the language translation line and letter translation. Cultural needs are addressed through practitioner assistance.

We also collect information from providers regarding additional languages spoken. This data helps us analyze the diversity of network physicians in relation to member preferences and needs.

We provide many services to assist members who have limited English proficiency including:

- Provider directories and website listings detail the language(s) spoken by each provider. Customer service representatives can also assist members in finding a physician that speaks his or her language.

- A companywide Language Access Plan (attached for reference) to support limited English proficient members and members with communication disabilities, including individuals who are deaf and hard of hearing (DHH) or are blind and have low vision (BLV).

- Members interacting with Aetna can self-identify at any point to request language assistance services.

- Our language line translation service includes over 200 different languages, American Sign Language, Braille and Large Print.

- We offer in-person interpreter services on a case-by-case basis.

- Written communication with our members and prospective members in their language with messages that are meaningful and relevant.

- A strategy to implement on-line multilingual consumer experience on key tools.

- All clinical services staff receives training in services required for compliance with the requirements of the Affordable Care Act, Section 1557, for limited English proficient members.

In addition to the above, when working with members having different cultural and linguistic needs, Aetna has care management programs designed for members with complex health needs – both physical and mental. Aetna care management assists members to get on, and stay on, a better path to health. Specific services include 24-hour nurse line support, provider search, cancer, maternity and joint center support, support programs for end-of-life treatment, digital tools, including the Aetna Health app, and educational videos.

Though this network/plan is offered outside of the marketplace, we monitor the participation of essential care providers that include low-income zip code areas or for members who reside in health professional shortage areas. As we decide to expand the reach of this network/plan into areas which are considered low-income or health professional shortage areas, we would conduct the necessary effort to ensure enrollees in such areas have adequate access to care without unreasonable delay per the detailed criteria outlined above for geographic accessibility and appointment availability.

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5. Aetna's methods for assessing the health care needs of covered persons.

Aetna employs several methods for assessing the various health care needs of enrollees and their satisfaction with services, including Population Health Management, Clinical Practice and Preventive Service Guidelines, Clinical Improvement Teams, Behavioral Health Preventive Health and Screening Programs., and Member Satisfaction Surveys. Each of these is described in further detail below.

Population Health Management (PHM)

The PHM strategy is comprehensive and meets the care needs of members across the continuum of care. It includes programs or initiatives that are directed towards members and providers. Member programs may be interactive or non-interactive to help members achieve their personal health goals. Non-direct member programs focus on collaboration with practitioners and providers to help lower costs through more efficient and effective patient management.

Clinical Practice and Preventive Services Guidelines

Aetna has designed a process to adopt guidelines relevant to the enrolled membership for the provision of preventive, acute, chronic, and behavioral health services. The guidelines are used as the clinical basis for disease management programs.

We adopt nationally accepted evidence-based clinical practice guidelines from recognized professional sources such as the American Diabetes Association (ADA), the American Heart Association (AHA), the American College of Cardiology (ACC), the American Psychiatric Association (APA), and the American Academy of Pediatrics (AAP).

We adopt nationally accepted evidence-based preventive services guidelines from the U.S. Preventive Services Task Force (USPSTF) for healthy adults and children with normal risks (Grade A and B) and the Centers for Disease Control and Prevention (CDC). Where there is lack of sufficient evidence to recommend for or against a preventive service by these sources, or there is a conflicting interpretation, we may adopt recommendations from other nationally recognized sources.

The review and adoption process are implemented for each adopted guideline at least every two years and when new scientific evidence or national standards are published prior to the two-year review date. We've established a policy and process for adopting and updating evidence-based Clinical Practice Guidelines and Preventive Services Guidelines from recognized sources.

To assess whether prevention and early detection health services are provided appropriately, we annually monitor and evaluate this performance as part of our Quality Management (QM) Program using such indicators as HEDIS (The Healthcare Effectiveness Data and Information Set) and other applicable measures and data as needed.

Clinical Improvement Teams

National QM staff work collaboratively with other business areas, such as pharmacy, disease management and other internal constituents, as appropriate. They critically analyze clinical indicators and HEDIS results, perform barrier analyses, and design and implement targeted improvement activities. They may also collaborate with external organizations to seek guidance and utilize existing resources and tools. This process focuses resources in the most efficient manner. Our clinical priorities are determined annually after rigorous analyses of health care data and may be modified as warranted by ongoing review of data.

Behavioral Health (BH) Preventive Health and Screening Programs

We maintain behavioral healthcare programs based on the needs of the covered population. Screening and prevention programs are designed to detect or prevent the incidence, emergence or worsening of behavioral disorders and adverse outcomes.

Practitioners and providers who participate on the Behavioral Health Quality Advisory Committee (BH QAC) provide input annually into the design and implementation of these programs. Information for designated screening programs is communicated to new and existing practitioners and providers as appropriate and at least

annually. Additionally, all members are informed about the availability of screening programs annually and are encouraged to participate in the programs.

> **6. Aetna's method of informing Covered persons of the plan's services and features, including cost sharing, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care.**

Aetna utilizes many methods to continually inform enrollees of their covered services and features of their plan. We provide a disclosure document to all subscribers upon initial enrollment and renewal which includes information regarding how to utilize plan benefits, member rights and responsibilities, how to file an appeal, and choosing and changing providers. In addition, detailed plan documents are distributed, including the certificate of coverage, summary of benefits, and member handbook. Finally, all members receive information regarding Aetna's member facing website, which includes much of the information members in a quick to access reference. The availability of each specific item is detailed further below.

Aetna's covered services and features are communicated to members electronically though our Member Onboarding outreach campaigns. The campaigns aim to establish onboarding steps (including portal registration), give an overview of plan benefits, encourage plan understanding, and completion of 'Next Best Actions'. Each thematic electronic correspondence includes personalized information according to the member's plan benefits.

Aetna makes covered services and features available to enrollees in multiple platforms including the pre-enrollment plan disclosure, the public facing website (aetna.com) and in the member handbook. These platforms contain detailed information specific to:

- o Choosing and changing providers
- o Accessing electronic versions of provider directories and requesting printed directories
- o Accessing language services
- o Understanding covered services

Aetna's grievance and appeal process is made available to enrollees in multiple sources. In addition to being printed in the member's handbook, the grievance and appeal process information is provided to enrollees in utilization review determination notices and explanations of benefits. Further, enrollees can find the grievance and appeal process on Aetna's public facing website, aetna.com. Additionally, Aetna's plan disclosure document provides information regarding the appeal process.

Aetna maintains both print and online provider directories. Aetna maintains provider online directories for contracted providers, facilities, and pharmacies. The online provider directory is updated 6 days a week, excluding holidays, Sundays, or interruptions due to system maintenance, upgrades or unplanned outages. All provider directory updates for any data elements in the directory that has been submitted and verified are included in the online directory updates. Aetna updates its online directory six (6) days a week when informed of and upon confirmation that a change is necessary, including after investigating an inaccuracy based on a complaint that a

provider was not accepting new patients, was not otherwise available, or whose contract information was incorrectly listed in the directory.

For complaints related to provider directory inaccuracies, including when a consumer reports that a listed provider is not accepting new patients, the turnaround time for an urgent request and directory update is five business days. For non-urgent, standard requests, the turnaround time is twelve business days. This process involves several of our internal departments from the time a complaint is received by Member Services, reviewed by Network Management and updated by Provider Data Services.

When a provider or provider group is no longer under contract, they will be removed from the online directory in the update process. Aetna's online provider search tool and is available to anyone on the website: https://www.aetna.com/individuals-families/find-a-doctor.html. Aetna also has a secure version of an online provider directory for Members to login and access their personalized provider search experience through our secure member website. Providers can use the public website, and have their own customized version available. Aetna's online provider directory and website displays a hyperlink to report a potential directory inaccuracy.

Aetna updates its printed provider directories annually in full. On a quarterly basis, Aetna creates print directory "addendums" which show providers that have been added to the networks and providers that have been removed from the networks. A printed provider directory copy may be requested by calling Aetna's toll-free telephone number. Aetna can also receive and process written requests for a printed copy of a provider directory. Requests logged via telephone contact are sent to a warehouse where the request is processed within 24 - 48 hours, and then sent to a mail consolidator to place the printed document into the U.S. Mail.

Choose a primary care physician (PCP): Most traditional or PPO-based plans don't require enrollees to select a PCP. However, some employers may require employees to do so. Aetna strongly encourages enrollees to choose one because enrollees PCP can help coordinate enrollees care and order tests and screenings. If it's an emergency, enrollees don't have to call their PCP first. Enrollees may change their PCP at any time. Women who are members may choose an Ob/Gyn as their PCP. Ob/Gyns acting as their PCP will provide the same services and follow the same guidelines as any other PCP. Enrollees may also be able to choose a pediatrician for their child(ren)'s PCP.

Coverage of emergency, urgent and specialty care services are discussed in detail in the enrollees' plan documents (Certificates of Coverage and Schedules of Benefits). Enrollees are also able to access information specific to coverage of emergency services from Aetna's public facing website. (https://www.aetna.com/faqs-health-insurance/emergency-care-faqs.html)

Aetna covers emergency room treatment and stabilization services for conditions that seem likely to create an emergency, based on the patient's current symptoms, regardless of whether the emergency care was received from a participating or non-participating provider. Prior authorization is never required for emergency medical conditions. The symptoms that have to do with the medical emergency often happen fast and are serious. An emergency medical condition is a medical condition showing itself of enough severity (including terrible pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of medical attention right away to result in the following:

- Placing the health of the person (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

In addition, Aetna also maintains a network of urgent care centers. Urgent care helps to prevent serious deterioration of a person's health following an unforeseen illness, injury, or condition. This non-preventive or non-routine health care service includes conditions that could not be managed without immediate care or treatment but do not require the level of care provided in an emergency room. Aetna covers urgent care by participating providers, inside or outside the plan service area, if the member's illness, injury, or condition is such that a delay in health care services until the member's physician is reasonably available may result in serious deterioration to the member's health. Prior authorization is not required for services that meet criteria for requiring urgent care received from participating providers; authorization is required for urgent care by nonparticipating providers.

Urgent care centers are not substitutes for ER care for true medical emergencies. Members should not seek medical care or treatment from an urgent care provider if their illness, injury, or condition is an emergency condition. In emergency situations, members should go directly to the hospital ER.

Certain non-emergent, non-urgent covered specialty services do require prior authorization. Aetna's public facing website provides utilization management information specific to types of specialty care requiring precertification and how to request authorization.

https://www.aetna.com/health-care-professionals/precertification/precertification-lists.html

Refer to the section above titled "Aetna's procedures for making and authorizing referrals within and outside its network" for details regarding how authorization to out-of-network providers can be requested and obtained if necessary.

The enrollee's plan documents provide information regarding how medical necessity is determined. Further, our clinical policy bulletins explain our policy for specific services and supplies. We use these bulletins and other resources to help guide individualized coverage decisions under our plans. Enrollees can find the bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html.

Aetna evaluates the availability of hospital-based provider services, including emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory at all participating hospitals on a regular basis. We enlist the assistance of our participating hospitals to identify the groups contracted to provide services at the hospital and assist with the contracting process as needed. We also ask contracted hospitals to notify us of changes to the hospital-based provider groups with which they contract to provide services.

In addition, we periodically run reports of claims received from hospital-based provider groups to monitor changes to the hospital-based practices providing services at contracted hospitals. Any newly identified groups are targeted for recruitment efforts.

7. Aetna's method for assessing consumer satisfaction

Member Satisfaction Surveys

The monitoring, evaluation and improvement of member experience is an important component of Aetna's Quality Management Program. This is accomplished using surveys and through the aggregation, analysis, and trending of member complaints. In addition, we encourage members to offer suggestions and express their concerns through the customer service telephone lines as well as our secure member website. Among the surveys utilized are:

NCQA Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey (Commercial)

The NCQA CAHPS survey is a public/private initiative of the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ) to provide standardized surveys of consumers' experiences with the health care system. Health plans report survey results as part of HEDIS data collection. NCQA uses survey results in health plan performance reports, to inform accreditation decisions and to create national benchmarks for care. NCQA compiles the Commercial CAHPS Health Plan Survey 5.0H Adult Version data in the NCQA Quality Compass ® which compares consumer satisfaction data across health plans and over time.

The NCQA survey includes a unique core set of questions, with some questions grouped to form composites, or summary results, of key areas of care and service. The surveys are sent to consumers to rate providers and health plans on several criteria, but they differ in that they go beyond the ratings questions to ask consumers to report on their personal experiences with health care services. This information is regarded as more specific, understandable, objective, and actionable than general rating alone.

Behavioral Health (BH) Member Experience Survey

This survey is administered semi-annually in accordance with NCQA guidelines to a sample drawn from the adult (ages 18 years and older) commercial and Medicare BH population who have accessed behavioral health care. The survey is designed to measure members' experience of care, both in the delivery of BH services and administrative services.

Member Experience Survey with Care Management Services

The Member Experience Survey is administered annually to members in the Case Management (CM), Disease Management (DM), and integrated programs that provide a combined CM/DM approach. The objectives of this study are to monitor and evaluate the experience among members who have utilized case management and/or disease management services and to determine the key drivers of satisfaction with the program. Insight into how well the program offerings are meeting member expectations helps to identify areas where the program is performing well and areas in need of improvement.

A separate survey is administered to members who receive case management services related to behavioral health conditions and includes survey items regarding both satisfaction and program effectiveness.

8. Aetna's method for using assessments of enrollee complaints and satisfaction to improve carrier performance

Aetna monitors network adequacy complaints, approvals for visits to non-participating providers at in-network benefit levels, and non-participating facility claims that are reimbursed at in-network benefit levels. Samples of these reports are included below (identifying data has been removed for illustrative purposes). Data from these reports may or may not necessarily indicate a network adequacy issue but do provide insight into instances in which a network adequacy issue might be present and are therefore reviewed regularly and incorporated into network recruitment plans and strategies.

9. Aetna's system for ensuring the coordination and continuity of care for covered persons referred to specialty providers, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning.

To ensure coordination and continuity of care for enrollees referred to specialty physicians, Aetna monitors appointment accessibility and member satisfaction with access to care. In addition, Aetna carefully monitors the coordination and continuity of care across medical networks and between behavioral health and medical care.

Aetna's proactive discharge planning is a process that anticipates needs for the timely coordination and implementation of a discharge plan of care. This process provides appropriate transition and continuity from the inpatient setting to the next level of care. The member's entire continuum of care is addressed. The discharge planning process begins at the time of notification and may include the hospital or other alternate care provider, Aetna, other health care providers, the treating practitioner, the member and the member's family or caregiver. The discharge plan considers the member's age, prior level of functioning, significant past medical history, anticipated discharge location, current medical condition including diagnosis, current level of functioning, family/community support, psychosocial factors, and potential barriers to discharge planning. The discharge plan may include referral to covered specialty programs and/or a variety of services or benefits to be utilized upon discharge (e.g., transfer to inpatient skilled nursing, sub-acute care or rehabilitation facility, home health care, community services, durable medical equipment).

Members in Aetna's with complex conditions are referred into our care management programs and are given extra help understanding their health care needs and benefits. We also help them access community services and other resources available to them.

10. Aetna's process for enabling Covered Persons to change Primary Care Professionals.

Choose a primary care physician (PCP): Most traditional or PPO-based plans don't require enrollees to select a PCP. However, some employers may require enrollees to do so. We strongly encourage enrollees to choose one because a PCP can help coordinate enrollees care and order tests and screenings. If it's an emergency, enrollees don't have to call their PCP first. Enrollees may change their PCP at any time. Women who are members may choose an Ob/Gyn as their PCP. Ob/Gyns acting as their PCP will provide the same services and follow the same guidelines as any other PCP. Enrollees may also be able to choose a pediatrician for enrollees' child(ren)'s PCP.

11. Aetna's proposed plan for providing continuity of care in the event of contract termination between the Health Carrier and any of its participating providers, or in the event of the Health Carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health earner's insolvency or other cessation of operations, and transferred to other providers in a timely manner

Aetna maintains policies and guidelines for notification of members when a provider or practitioner leaves the network. The guidelines apply regulatory requirements (State and Federal) and accreditation standards. Additionally, they provide continuity and coordination of care for members when providers or practitioners terminate from the network.

Aetna will make a good faith effort to provide notice of a provider contract termination within thirty (30) working days within receipt or issuance of a notice of termination to all covered persons who are patients seen on a regular basis of that provider. Members are informed in the notification of provider termination that they may continue their care for a certain period after the termination date if they are in a course of treatment and are invited to call the number on their Aetna ID card for assistance on the continuation of care request.

Continuity of care will continue until the active course of treatment is completed, or until 120 days after notification to the member of the termination of the contractual relationship with the individual provider.

A member who is undergoing care for pregnancy and who becomes entitled to continuity of care after commencement of the second trimester will receive care until the later of the following:

- The 45th day after the birth or
- As long as the member continues under an active course of treatment, but not later than 120 days after the date of notification to the member of the termination of the contractual relationship with the individual provider

Continuity of care authorizations provide that coverage will be provided at the member's in-network benefit level to ensure members are held harmless from balance billing, by ensuring that the individual provider adheres to the medical services contract and accept the reimbursement rate applicable at the time of contract termination, or

on a case-by-case basis negotiating specified reimbursement rates for the episode of care. In addition, members with continuity of care situations will be assisted in identifying and transitioning ongoing care needs to new in-network providers.

Upon termination of a significant provider(s) from the network, adequacy gap analyses are conducted to determine if the termination created geographic access gaps for members. In this case, the network management team will undertake efforts to identify and recruit additional providers of the type and location needed to address the inadequacy.

Aetna's contracts with participating providers contain language which protects members in the event of company's "insolvency or cessation of operations". Aetna's provider contracts require that participating providers continue to provide covered services to all members for the period for which premium has been paid; and for members confined in an inpatient facility on the date of insolvency or other cessation of operations until medically appropriate to discharge.

Aetna's Business Continuity Program exists in the event of a natural disaster or other event which impairs the company's ability to continue normal operations. Aetna will rapidly assess events, respond to events to minimize disruption and rapidly recover critical business functions, and provide timely communications to Aetna employees, critical third parties, customers, and the public. Communications to customers, brokers/agents, members, plan sponsors, provider networks, employees, critical third parties, media, and the public are coordinated by the Corporate Event Response Team (CERT).