

**AETNA HEALTH OF CALIFORNIA INC.
(CALIFORNIA)**

GROUP AGREEMENT COVER SHEET

Contract Holder: The Government of the District of Columbia

Contract Holder Number: 172614
363

HMO Referred Benefit Level: CITIZEN PLAN Benefits Package

Effective Date: 12:01 a.m. on January 1, 2013

Term of Group Agreement: The **Initial Term** shall be: From January 1, 2013 through December 31, 2013
Thereafter, **Subsequent Terms** shall be: From January 1st through December 31st

Premium Due Dates: The **Group Agreement Effective Date** and the 1st day of each succeeding calendar month.

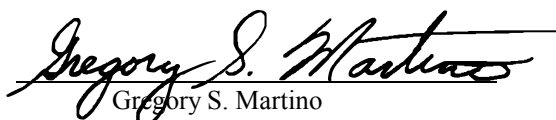
Governing Law: Federal law and the laws of California.

Notice Address for HMO:

Aetna Health of California Inc.
Employer Services Contract Coordinator
1385 East Shaw
Fresno, CA 93710

The signature below is evidence of Aetna Health's acceptance of the **Contract Holder's** Group Application on the terms hereof and constitutes execution of the **Group Agreement(s)** attached hereto on behalf of Aetna Health of California Inc.

By:


Gregory S. Martino
Vice President

Contract Holder Name: The Government of the District of Columbia
Contract Holder Number: 172614
Contract Holder Locations: 363
Contract Holder Group Agreement Effective Date: January 1, 2013

**AETNA HEALTH OF CALIFORNIA INC.
(CALIFORNIA)**

GROUP AGREEMENT

This **Group Agreement** is entered into by and between Aetna Health of California Inc. (“**HMO**”) and the **Contract Holder** specified in the attached Cover Sheet. This **Group Agreement** shall be effective on the **Effective Date** specified in the Cover Sheet, and shall continue in force until terminated as provided herein.

In consideration of the mutual promises hereunder and the payment of **Premiums** and fees when due, **We** will provide coverage for benefits in accordance with the terms, conditions, limitations and exclusions set forth in this **Group Agreement**.

Upon acceptance by **Us** of **Contract Holder’s** Group Application, and upon receipt of the required initial **Premium**, this **Group Agreement** shall be considered to be agreed to by **Contract Holder** and **Us**, and is fully enforceable in all respects against **Contract Holder** and **Us**.

SECTION 1. DEFINITIONS

- 1.1 The terms “**Contract Holder**”, “**Effective Date**”, “**Initial Term**”, “**Premium Due Date**” and “**Subsequent Terms**” will have the meaning set forth in the attached Cover Sheet. If any of such terms are undefined in the Cover Sheet, such undefined terms shall have the following meaning:
- “**Effective Date**” would mean the date health coverage commences for the **Contract Holder**.
 - “**Initial Term**” would be the period following the **Effective Date** as indicated on the Cover Sheet.
 - “**Premium Due Date(s)**” would be the **Effective Date** and each monthly anniversary of the **Effective Date**.
 - “**Subsequent Term(s)**” would mean the periods following the **Initial Term** as indicated on the Cover Sheet.
- 1.2 The terms “**HMO**”, “**Us**”, “**We**” or “**Our**” mean Aetna Health of California Inc.
- 1.3 “**EOC**” means the Evidence of Coverage issued pursuant to this **Group Agreement**.
- 1.4 “**Grace Period**” is defined in Section 3.2.
- 1.5 “**Group Agreement**” means the **Contract Holder’s** Group Application, this document, the attached Cover Sheet; the **EOC** and Schedule of Benefits issued hereunder; the initial rate sheet and any subsequent indication of rates issued by **Us** in connection with this **Group Agreement**; and any riders, amendments, endorsements, inserts or attachments issued pursuant hereto, all of which are incorporated into and made a part of this **Group Agreement**.
- 1.6 “**Party, Parties**” means **HMO** and **Contract Holder**.
- 1.7 “**Premium(s)**” is defined in Section 3.1.
- 1.8 “**Renewal Date**” means the first day following the end of the **Initial Term** or any **Subsequent Term**.
- 1.9 “**Term**” means the **Initial Term** or any **Subsequent Term**.

- 1.10 Capitalized and bolded terms not defined in this **Group Agreement** shall have the meaning set forth in the **EOC**. In the event of a conflict between the terms of this **Group Agreement** and the terms of the **EOC**, the terms of this **Group Agreement** shall prevail.

SECTION 2. COVERAGE

- 2.1 **Covered Benefits.** We will provide coverage for **Covered Benefits** to **Members** subject to the terms and conditions of this **Group Agreement**. Coverage will be provided in accordance with the reasonable exercise of **Our** business judgment, consistent with applicable law. **Members** covered under this **Group Agreement** are subject to all of the conditions and provisions contained herein and in the incorporated documents.
- 2.2 **Policies and Procedures.** We have the right to adopt reasonable policies, procedures, rules, and interpretations of this **Group Agreement** and the **EOC** in order to promote orderly and efficient administration.

SECTION 3. PREMIUMS

- 3.1 **Premiums.** **Contract Holder** shall pay **Us** on or before each **Premium Due Date** a monthly advance premium (the “**Premium**”) determined in accordance with the **Premium** rates and the manner of calculating **Premiums** specified by **HMO**. **Premium** rates and the manner of calculating **Premiums** may be adjusted in accordance with Section 3.4 below. **Premiums** are subject to adjustment, if any, for partial month participation as specified in Section 3.3 below. Membership as of each **Premium Due Date** will be determined by **Us** in accordance with **Our Member** records. A check does not constitute payment until it is honored by a bank. We may return a check issued against insufficient funds without making a second deposit attempt. We may accept a partial payment of **Premium** without waiving our right to collect the entire amount due.
- 3.2 **Past Due Premiums.** If a **Premium** payment is not paid in full by **Contract Holder** on or before the **Premium Due Date**, a late payment charge of 1 ½% of the total amount due per month (or partial month) will be added to the amount due. If all **Premiums** are not received before the end of a 30 day grace period (the “**Grace Period**”), this **Group Agreement** will be automatically terminated pursuant to Section 6.3 hereof.

If the **Group Agreement** terminates for any reason, **Contract Holder** will continue to be held liable for all **Premiums** due and unpaid before the termination, including, but not limited to, **Premium** payments for any period of time the **Group Agreement** is in force during the **Grace Period**. **Members** shall also remain liable for **Member** cost sharing and other required contributions to coverage for any period of time the **Group Agreement** is in force during the **Grace Period**. We may recover from **Contract Holder** **Our** costs of collecting any unpaid **Premiums**, including reasonable attorneys’ fees and costs of suit.

- 3.3 **Prorations.** **Premiums** shall be paid in full for **Members** whose coverage is in effect on the **Premium Due Date** or whose coverage terminates on the last day of the **Premium** period.

Premiums for **Members** whose coverage is effective on a day other than the first day of the billing month or whose coverage terminates on a day other than the last day of the billing month shall be adjusted as indicated below:

- If membership becomes effective between the 1st through the 15th of the month, the **Premium** for the whole month is due. If membership is effective between the 16th through the 31st of the month, no **Premium** is due for the first month of membership.
- If membership terminates between the 1st through the 15th of the month, no **Premium** is due for that month. If membership terminates between the 16th through the 31st of the month, the **Premium** for the whole month is due.

- 3.4 **Changes in Premium.** We may also adjust the **Premium** rates and/or the manner of calculating **Premiums** effective as of the contract renewal date, upon 30 days prior written notice to **Contract Holder**. Small employers' **Premium** rates will remain in effect for no less than 6 months, for the **Initial Term** and **Subsequent Terms**.

At the end of a Term, We may declare an experience credit. The amount of each credit We declare will be returned to Contract Holder. Upon the request of the Contract Holder, part or all of it will be applied against the payment of Premium or in any other manner as may be agreed to by the Contract Holder and Us. If the sum of Subscriber contributions exceed the sum of Premiums (after applying any experience credits), the excess will be used by the Contract Holder for the sole benefit of the Subscribers. The Contract Holder is solely responsible for the distribution of such excess.

- 3.5 **Membership Adjustments.** We may, at **Our** discretion, make retroactive adjustments to the **Contract Holder's** billings for the termination of **Members** not posted to previous billings. However, **Contract Holder** may only receive a maximum of 2 calendar month's credit for **Member** terminations that occurred more than 30 days before the date **Contract Holder** notified **Us** of the termination. **We** may reduce any such credits by the amount of any payments **We** may have made on behalf of such **Members** (including capitation payments and other claim payments) before **We** were informed their coverage had been terminated. Retroactive additions will be made at **Our** discretion based upon eligibility guidelines, as set forth in the **EOC**, and are subject to the payment of all applicable **Premiums**.

SECTION 4. ENROLLMENT

- 4.1 **Open Enrollment.** As described in the **EOC**, **Contract Holder** will offer enrollment in **HMO**:

- at least once during every twelve month period during the **Open Enrollment Period**; and
- within 31 days from the date the individual and any dependent becomes eligible for coverage.

Eligible individuals and dependents who are not enrolled within the **Open Enrollment Period** or 31 days of becoming eligible, may be enrolled during any subsequent **Open Enrollment Period**. Coverage will not become effective until confirmed by **Us**. **Contract Holder** agrees to hold the **Open Enrollment Period** consistent with the **Open Enrollment Period** applicable to any other group health benefit plan being offered by the **Contract Holder** and in compliance with applicable law. The **Contract Holder** shall permit **Our** representatives to meet with eligible individuals during the **Open Enrollment Period** unless the parties agree upon an alternate enrollment procedure. As described in the **EOC**, other enrollment periods may apply.

- 4.2 **Waiting Period.** There may be a waiting period before individuals are eligible for coverage under this **Group Agreement**. The waiting period, if any, is specified on the **Schedule of Benefits**.
- 4.3 **Eligibility.** The number of eligible individuals and dependents and composition of the group, the identity and status of the **Contract Holder**, the eligibility requirements used to determine membership in the group, and the participation and contribution standards applicable to the group which exist at the **Effective Date** of this **Group Agreement** are material to the execution and continuation of this **Group Agreement** by **Us**. The **Contract Holder** shall not, during the term of this **Group Agreement**, modify the **Open Enrollment Period**, the waiting period as described on the **Schedule of Benefits**, or any other eligibility requirements as described in the **EOC** and on the **Schedule of Benefits**, for the purposes of enrolling **Contract Holder's** eligible individuals and dependents under this **Group Agreement**, unless **We** agree to the modification in writing.

SECTION 5. RESPONSIBILITIES OF THE CONTRACT HOLDER

In addition to other obligations set forth in this **Group Agreement**, **Contract Holder** agrees to:

- 5.1 **Records.** Furnish to **Us**, on a monthly basis (or as otherwise required), on our form (or such other form as **We** may reasonably approve) by facsimile (or such other means as **We** may reasonably approve), such information as **We** may reasonably require to administer this **Group Agreement**. This includes, but is not limited to, information needed to enroll members of the **Contract Holder**, process terminations, and effect changes in family status and transfer of employment of **Members**.

Contract Holder represents that all enrollment and eligibility information that has been or will be supplied to **Us** is accurate. **Contract Holder** acknowledges that **We** can and will rely on such enrollment and eligibility information in determining whether an individual is eligible for **Covered Benefits** under this **Group Agreement**. To the extent such information is supplied to **Us** electronically, **Contract Holder** agrees to:

- Maintain a reasonably complete record of such information (in electronic or hard copy format, including evidence of coverage elections, evidence of eligibility, changes to such elections and terminations) for at least seven years, and to make such information available to **Us** upon request.
- Obtain from all **Subscribers** a "Disclosure of Healthcare Information" authorization in the form currently being used by **Us** in the enrollment process (or such other form as **We** may reasonably approve).

We will not be liable to **Members** for the fulfillment of any obligation prior to information being received in a form satisfactory to **Us**. **Contract Holder** must notify **Us** of the date in which a **Subscriber's** employment ceases for the purpose of termination of coverage under this **Group Agreement**. Subject to applicable law, unless otherwise specifically agreed to in writing, **We** will consider **Subscriber's** employment to continue until the earlier of:

- until stopped by the **Contract Holder**;
- if **Subscriber** has stopped working due to temporary lay off or leave of absence, not beyond the end of the policy month after the policy month in which the absence started; and
- if **Subscriber** stopped working due to disability, not beyond the end of the 30th policy month after the month in which the absence started.

- 5.2 **Access.** Make payroll and other records directly related to **Member's** coverage under this **Group Agreement** available to **Us** for inspection, at **Our** expense, at **Contract Holder's** office, during regular business hours, upon reasonable advance request. This provision shall survive termination of this **Group Agreement**.

- 5.3 **Forms.** Distribute materials to **HMO Members** regarding enrollment, health plan features, including **Covered Benefits** and exclusions and limitations of coverage. **Contract Holder** shall, within 31 days of receipt from an eligible individual, forward all completed enrollment information and other required information to **Us**.

- 5.4 **Policies and Procedures; Compliance Verification.** Comply with all policies and procedures established by **Us** in administering and interpreting this **Group Agreement**. **Contract Holder** shall, upon request, provide a certification of its compliance with **Our** participation and contribution requirements and the requirements for a group as defined under applicable law or regulation.

- 5.5 **Continuation Rights and Conversion.** Notify all eligible **Members** of their right to continue or convert coverage pursuant to applicable law.

- 5.6 **Contract Holder Obligations Under COBRA.** Under federal law, an employer who employs twenty (20) or more employees on a typical business day during the prior calendar year must provide **Members** with the opportunity to elect COBRA continuation coverage in certain circumstances where coverage would otherwise terminate. Such **Contract Holders** and their group health plan's administrators (in certain cases, the employer may be the plan administrator) have the obligation to: (1) provide **Members** with notice of the opportunity to elect continuation coverage; and (2) administer the continuation coverage. The obligation to provide notice includes both general notification to **Members** of their right to elect continuation coverage and specific notification of the right to continuation coverage within a specific time period after the occurrence of the event which triggers the continuation coverage option.

Contract Holder hereby acknowledges its legal obligations and agrees to abide by applicable legal requirements with respect to COBRA continuation coverage. **Contract Holder** also agrees to forward to **HMO** in a timely manner copies of any and all notices provided to **Members** regarding COBRA continuation coverage.

Contract Holder Obligations Under Cal-COBRA. Under California law, a health care service plan that contracts with employers who employ two (2) through nineteen (19) eligible employees on a typical business day during the prior calendar year is required to provide **Members** with the opportunity to elect Cal-COBRA continuation coverage in certain circumstances where coverage would otherwise terminate. **HMO** will administer or contract for the administration of continuation coverage under Cal-COBRA. Nonetheless, **Contract Holder** must provide certain notices to **HMO** and to **Members** as described below. **Contract Holder** must notify **HMO** in writing of any employee who has a qualifying event defined in the Continuation and Conversion section, Item 2 – Cal-COBRA Continuation Coverage of the **EOC** within thirty (30) days of the qualifying event. Such notice must be separate from other communications from **Contract Holder** and must specifically reference Cal-COBRA. Notations of additions and/or deletions on monthly invoices will not constitute sufficient notice. **Contract Holder** must further provide written notice to **HMO** within thirty (30) days of the date the **Contract Holder** becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Section 1161 et seq.

Contract Holder must also notify qualified beneficiaries of the ability to continue coverage prior to terminating a group agreement (such as this **Group Agreement**) under which a qualified beneficiary is receiving continuation coverage. This notification shall be provided either thirty (30) days prior to the agreement termination or when all other enrolled employees are notified, whichever is greater. **Contract Holder** must notify any successor plan in writing of the qualified beneficiaries currently receiving continuation coverage to enable the successor plan, contracting employer, or administrator to provide such qualified beneficiaries with the premium information, enrollment forms, and disclosures necessary to allow the qualified beneficiaries to continue coverage under other available group plans.

If **Contract Holder** fails to meet these obligations, **HMO** will not provide continuation coverage to qualified beneficiaries under Cal-COBRA. **Contract Holder** hereby acknowledges its obligations and agrees to comply with all applicable legal requirements with respect to Cal-COBRA continuation coverage. **Contract Holder** also agrees to forward to **HMO** in a timely manner copies of any notice provided to **Members** regarding Cal-COBRA continuation coverage.

- 5.7 **ERISA Requirements.** Maintain responsibility for making reports and disclosures required by the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), including the creation, distribution and final content of summary plan descriptions, summary of material modifications and summary annual reports.

SECTION 6. TERMINATION

- 6.1 **Termination by Contract Holder.** This **Group Agreement** may be terminated by **Contract Holder** as of any **Premium Due Date** by providing **Us** with 30 days prior written notice. However, **We** may in **Our** discretion accept an oral indication by **Contract Holder** or its agent or broker of intent to terminate.
- 6.2 **Non-Renewal by Contract Holder.** **We** may request from **Contract Holder** a written indication of their intention to renew or non-renew this **Group Agreement** at any time during the final three months of any **Term**. If **Contract Holder** fails to reply to such request within the timeframe specified the **Contract Holder** shall be deemed to have provided notice of non-renewal to **Us** and this **Group Agreement** shall be deemed to terminate automatically as of the end of the **Term**. Similarly, upon **Our** written confirmation to **Contract Holder**, **We** may accept an oral indication by **Contract Holder** or its agent or broker of intent to non-renew as **Contract Holder's** notice of termination effective as of the end of the **Term**.
- 6.3 **Termination by Us.** This **Group Agreement** will terminate as of the last day of the **Grace Period** if the **Premium** remains unpaid at the end of the **Grace Period**.

This **Group Agreement** may also be terminated by **Us** as follows:

- Immediately upon notice to **Contract Holder** if **Contract Holder** has performed any act or practice that constitutes fraud or made any intentional misrepresentation of a material fact relevant to the coverage provided under this **Group Agreement**;
 - Immediately upon notice to **Contract Holder** if **Contract Holder** no longer has any enrollee under the Plan who resides or works in the **Service Area**;
 - Upon 30 days written notice to **Contract Holder** if **Contract Holder** (i) breaches a provision of this **Group Agreement** and such breach remains uncured at the end of the notice period; (ii) ceases to meet **Our** requirements for an employer group or association; (iii) fails to meet **Our** contribution or participation requirements applicable to this **Group Agreement** (which contribution and participation requirements are available upon request); (iv) fails to provide the certification required by Section 5.4 within a reasonable period of time specified by **Us**; or (v) changes its eligibility or participation requirements without **Our** consent;
 - Upon 90 days written notice to **Contract Holder** (or such shorter notice as may be permitted by applicable law, but in no event less than 30 days) if **We** cease to offer the product to which the **Group Agreement** relates;
 - Upon 180 days written notice to **Contract Holder** (or such shorter notice as may be permitted by applicable law, but in no event less than 30 days) if **We** cease to offer coverage in a market in which **Members** covered under this **Group Agreement** reside;
 - Upon 30 days written notice to **Contract Holder** for any other reason which is acceptable to the Department of Managed Health Care and consistent with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or by applicable federal rules and regulations, as amended.
- 6.4 **Effect of Termination.** No termination of this **Group Agreement** will relieve either party from any obligation incurred before the date of termination. When terminated, this **Group Agreement** and all coverage provided hereunder will end at 12:00 midnight on the effective date of termination. **We** may charge the **Contract Holder** a reinstatement fee if coverage is terminated and subsequently reinstated under this **Group Agreement**. Upon termination, **We** will provide **Members** with Certificates of Creditable Coverage which will show evidence of a **Member's** prior health coverage with **Us** for a period of up to 18 months prior to the loss of coverage.
- 6.5 **Notice to Subscribers and Members.** It is the responsibility of **Contract Holder** to notify the **Members** of the termination of the **Group Agreement** in compliance with all applicable laws. However, **We** reserve

the right to notify **Members** of termination of the **Group Agreement** for any reason, including non-payment of **Premium**. In accordance with the **EOC**, the **Contract Holder** shall provide written notice to **Members** of their rights upon termination of coverage.

SECTION 7. PRIVACY OF INFORMATION

- 7.1 **Compliance with Privacy Laws.** We and **Contract Holder** will abide by all applicable laws and regulations regarding confidentiality of individually identifiable health and other personal information, including the privacy requirements of HIPAA.
- 7.2 **Disclosure of Protected Health Information.** We will not provide protected health information (“PHI”), as defined in HIPAA, to **Contract Holder**, and **Contract Holder** will not request PHI from **Us**, unless **Contract Holder** has either:
- provided the certification required by 45 C.F.R. § 164.504(f) and amended **Contract Holder’s** plan documents to incorporate the necessary changes required by such rule; or
 - provided confirmation that the PHI will not be disclosed to the “plan sponsor”, as such term is defined in 45 C.F.R. § 164.501.
- 7.3 **Brokers and Consultants.** To the extent any broker or consultant receives PHI in the underwriting process or while advocating on behalf of a **Member**, **Contract Holder** understands and agrees that such broker or consultant is acting on behalf of **Contract Holder** and not **Us**. We are entitled to rely on **Contract Holder’s** representations that any such broker or consultant is authorized to act on **Contract Holder’s** behalf and entitled to have access to the PHI under the relevant circumstances.

SECTION 8. INDEPENDENT CONTRACTOR RELATIONSHIPS

- 8.1 **Relationship Between Us and Participating Providers.** The relationship between **Us** and **Participating Providers** is a contractual relationship among independent contractors. **Participating Providers** are not agents or employees of **Us** nor are **We** an agent or employee of any **Participating Provider**.

Participating Providers are solely responsible for any health services rendered to their **Member** patients. We make no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any **Physician**, **Hospital** or other **Participating Provider**. A **Provider’s** participation may be terminated at any time without advance notice to the **Contract Holder** or **Members**, subject to applicable law. **Participating Providers** provide health care diagnosis, treatment and services for **Members**. We administer and determine plan benefits.

- 8.2 **Relationship Between the Parties.** The relationship between the **Parties** is a contractual relationship between independent contractors. Neither **Party** is an agent or employee of the other in performing its obligations pursuant to this **Group Agreement**.

SECTION 9. MISCELLANEOUS

- 9.1 **Delegation and Subcontracting.** **Contract Holder** acknowledges and agrees that **We** may enter into arrangements with third parties to delegate functions hereunder such as utilization management, quality assurance and provider credentialing, as **We** deem appropriate in **Our** sole discretion and as consistent with applicable laws and regulations. **Contract Holder** also acknowledges that **Our** arrangements with third party vendors (i.e. pharmacy, behavioral health) are subject to change in accordance with applicable laws and regulations.
- 9.2 **Accreditation and Qualification Status.** We may from time to time obtain voluntary accreditation or qualification status from a private accreditation organization or government agency. We make no express or implied warranty about **Our** continued qualification or accreditation status.

- 9.3 **Prior Agreements; Severability.** As of the **Effective Date**, this **Group Agreement** replaces and supersedes all other prior agreements between the **Parties** as well as any other prior written or oral understandings, negotiations, discussions or arrangements between the **Parties** related to matters covered by this **Group Agreement** or the documents incorporated herein. If any provision of this **Group Agreement** is deemed to be invalid or illegal, that provision shall be fully severable and the remaining provisions of this **Group Agreement** shall continue in full force and effect.
- 9.4 **Amendments.** This **Group Agreement** may be amended as follows:
- This **Group Agreement** shall be deemed to be automatically amended to conform with all rules and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over **Us**;
 - By written agreement between both **Parties**; or
 - By **Us** upon 30 days written notice to **Contract Holder**.
- The **Parties** agree that an amendment does not require the consent of any employee, **Member** or other person. Except for automatic amendments to comply with law, all amendments to this **Group Agreement** must be approved and executed by **Us**. No other individual has the authority to modify this **Group Agreement**; waive any of its provisions, conditions, or restrictions; extend the time for making a payment; or bind **Us** by making any other commitment or representation or by giving or receiving any information.
- 9.5 **Clerical Errors.** Clerical errors or delays by **Us** in keeping or reporting data relative to coverage will not reduce or invalidate a **Member's** coverage. Upon discovery of an error or delay, an adjustment of **Premiums** shall be made. **We** may also modify or replace a **Group Agreement**, **EOC** or other document issued in error.
- 9.6 **Claim Determinations.** **We** have complete authority to review all claims for **Covered Benefits** under this **Group Agreement**. In exercising such responsibility, **We** shall have discretionary authority to determine whether and to what extent eligible individuals and beneficiaries are entitled to coverage and to construe any disputed or doubtful terms under this **Group Agreement**, the **EOC** or any other document incorporated herein. **We** shall be deemed to have properly exercised such authority unless **We** abuse our discretion by acting arbitrarily and capriciously. **Our** review of claims may include the use of commercial software (including Claim Check) and other tools to take into account factors such as an individual's claims history, a **Provider's** billing patterns, complexity of the service or treatment, amount of time and degree of skill needed and the manner of billing.
- 9.7 **Misstatements.** If any fact as to the **Contract Holder** or a **Member** is found to have been misstated, an equitable adjustment of **Premiums** may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.
- 9.8 **Incontestability.** Except as to a fraudulent misstatement, or issues concerning **Premiums** due:
- No statement made by **Contract Holder** or any **Member** shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing.
 - No statement made by **Contract Holder** shall be the basis for voiding this **Group Agreement** after it has been in force for two years from its effective date.
- 9.9 **Assignability.** No rights or benefits under this **Group Agreement** are assignable by **Contract Holder** to any other party unless approved by **HMO**.
- 9.10 **Waiver.** **Our** failure to implement, or insist upon compliance with, any provision of this **Group Agreement** or the terms of the **EOC** incorporated hereunder, at any given time or times, shall not constitute a waiver of **Our** right to implement or insist upon compliance with that provision at any other

time or times. This includes, but is not limited to, the payment of **Premiums** or benefits. This applies whether or not the circumstances are the same.

- 9.11 **Notices.** Any notice required or permitted under this **Group Agreement** shall be in writing and shall be deemed to have been given on the date when delivered in person; or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid, and properly addressed to the address set forth in the Group Application or Cover Sheet, or to any more recent address of which the sending party has received written notice or, if delivered by facsimile or other electronic means, on the date sent by facsimile or other electronic means.
- 9.12 **Third Parties.** This **Group Agreement** shall not confer any rights or obligations on third parties except as specifically provided herein.
- 9.13 **Non-Discrimination.** **Contract Holder** agrees to make no attempt, whether through differential contributions or otherwise, to encourage or discourage enrollment in **HMO** of eligible individuals and eligible **Dependents** based on health status or health risk.
- 9.14 **Applicable Law.** This **Group Agreement** shall be governed and construed in accordance with applicable federal law and the law of the state specified in the Cover Sheet or, if no state law is specified, **Our** domicile state.
- 9.15 **Inability to Arrange Services.** If due to circumstances not within **Our** reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of **Our Participating Providers** or entities with whom **We** have contracted for services under this **Group Agreement**, or similar causes, the provision of medical or **Hospital** benefits or other services provided under this **Group Agreement** is delayed or rendered impractical, **We** shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid **Premiums** held by **Us** on the date such event occurs. **We** are required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.
- 9.16 **Use of the HMO Name and all Symbols, Trademarks, and Service Marks.** **We** reserve the right to control the use of **Our** name and all symbols, trademarks, and service marks presently existing or subsequently established. **Contract Holder** agrees that it will not use such name, symbols, trademarks, or service marks in advertising or promotional materials or otherwise without **Our** prior written consent and will cease any and all usage immediately upon **Our** request or upon termination of this **Group Agreement**.
- 9.17 **Dispute Resolution.** Any controversy, dispute or claim between **Us** on the one hand and one or more **Interested Parties** on the other hand arising out of or relating to the **Group Agreement**, whether stated in tort, contract, statute, claim for benefits, bad faith, professional liability or otherwise ("Claim"), shall be settled by confidential binding arbitration administered by the American Arbitration Association ("AAA") before a sole arbitrator ("Arbitrator"). Judgment on the award rendered by the Arbitrator ("Award") may be entered by any court having jurisdiction thereof. If the AAA declines to administer the case and the parties do not agree on an alternative administrator, a sole neutral arbitrator shall be appointed upon petition to a court having jurisdiction. **We** and **Interested Parties** hereby give up our rights to have Claims decided in a court before a jury.

Any Claim alleging wrongful acts or omissions of **Participating** or **Non-Participating Providers** shall not include **HMO**. A **Member** must exhaust all grievance, appeal and independent external review procedures prior to the commencement of an arbitration hereunder. No person may recover any damages arising out of or related to the failure to approve or provide any benefit or coverage beyond payment of or coverage for the benefit or coverage where (i) **We** have made available independent external review and (ii) **We** have followed the reviewer's decision. Punitive damages may not be recovered as part of a Claim under any circumstances. No **Interested Party** may participate in a representative capacity or as a member of any class in any proceeding arising out of or related to the **Group Agreement**. This agreement to arbitrate

shall be specifically enforced even if a party to the arbitration is also a party to another proceeding with a third party arising out of the same matter.

- 9.18 **Workers' Compensation.** **Contract Holder** is responsible for protecting **Our** interests in any Workers' Compensation claims or settlements with any eligible individual. **We** shall be reimbursed for all paid medical expenses which have occurred as a result of any work related injury that is compensable or settled in any manner.

On or before the **Effective Date** of this **Group Agreement** and upon renewal, **Contract Holder** shall submit proof of their Workers' Compensation coverage or an exclusion form which has been accepted by the applicable regulatory authority governing Workers' Compensation. Upon **Our** request, **Contract Holder** shall also submit a monthly report to **Us** listing all Workers' Compensation cases. Such list will contain the name, social security number, date of loss and diagnosis of all applicable eligible individuals.

- 9.19 **Subrogation.** If **HMO** provides health care benefits under this **Group Agreement** to a **Member** for injuries or illness for which a third party is or may be responsible, then **HMO** retains the right to repayment (a lien), to the extent permitted by law for the value of all benefits provided by **HMO** that are associated with the injury or illness for which the third party is or may be responsible, plus the costs to perfect the lien. In some cases, **Participating Providers** may assert the **HMO's** lien. Some **Providers** also have lien rights that are independent of the **HMO's** rights.

HMO's rights of recovery are described in the Third Party Liability and Right of Recovery section of the **EOC**. The sum which **HMO** may actually recover is limited as follows:

- No lien may exceed the sum of the reasonable costs actually paid by **HMO** to perfect the lien and one of the following:
 - a. for health care services provided on a non-capitated basis, the amount actually paid by **HMO** to any treating **Provider**, or
 - b. for health care services provided on a capitated basis, the amount equal to 80 percent of the **Reasonable Charge** for the same services by **Providers** that provide health care services on a non-capitated basis in the geographic region in which the services were rendered, or
 - c. If the **Member** received services on a capitated basis and on a non-capitated basis and the **HMO** covered services on a capitated basis and paid for the services the **Member** received on a non-capitated basis, the lien may not exceed the sum of the reasonable costs actually paid to perfect the lien and the amounts determined according to (a) and (b) above.
- If the **Member** engaged an attorney, then the lien may not exceed the lesser of the following amounts:
 - a. The maximum amount determined by 1.a, 1.b or 1.c above, whichever is applicable, or
 - b. One-third of the amount due to the **Member** under any final judgment, compromise, or settlement agreement.
- If the **Member** did not engage an attorney, then the lien may not exceed the lesser of the following amounts:
 - a. The maximum amount determined by 1.a, 1.b or 1.c above, whichever is applicable, or
 - b. One-half of the amount due to the **Member** under any final judgment, compromise, or settlement agreement.

- Where a final judgment includes a special finding by a judge, jury or arbitrator, that the **Member** was partially at fault, the lien as determined by 1.a, 1.b or 1.c above shall be reduced by the same comparative fault percentage by which the **Member's** recovery amount was reduced.
- The lien amount determined by 1.a, 1.b or 1.c above is subject to pro rata reduction, commensurate with the **Member's** attorney's fees and costs, in accordance with the common fund doctrine.
- Liens against workers' compensation claims are not subject to the requirements listed above.

**AETNA HEALTH OF CALIFORNIA INC.
(CALIFORNIA)**

GROUP AGREEMENT AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The section 6.5 of the **Group Agreement** is hereby deleted and replaced with the following:

6.5 **Notice to Subscribers and Members.** It is the responsibility of **Contract Holder** to notify the **Members** of the termination of the **Group Agreement** in compliance with all applicable laws. In the event we provide notice of cancellation for non-payment of premium to **Contract Holder**, **Contract Holder** agrees to promptly mail a legible, true copy of the notice of cancellation to all **Subscribers** at their current address. The notice of cancellation to **Contract Holder** will include:

- the date and time coverage will terminate
- the cause for cancellation, including reference to the applicable clause in the **Group Agreement**
- a statement that the cause for cancellation was not due to the **Member's** health status or requirements for health care services
- that a **Member** who alleges that cancellation was due to the **Member's** health status may request a review of cancellation by the Department of Managed Health Care
- information regarding the **Member's** COBRA, Cal-COBRA, conversion Coverage and HIPAA Individual coverage.

Such notice must be mailed to **Subscribers** 15 days prior to the date of termination. If the **Contract Holder** fails to deliver the above-referenced notice of cancellation and deliver proof of mailing to **Us**, **We** will mail notice directly to the individual **Subscribers**: coverage will not end until the 15th day after **HMO** mails the notice. The **Contract Holder** is required to reimburse **Us** for the costs of such mailing and for all premiums accrued do to the non-performance of this contractual obligation.

However, **We** reserve the right to notify **Members** of termination of the **Group Agreement** for any reason, including non-payment of **Premium**.

HEALTH CARE REFORM CONTRIBUTION CHANGE NOTICE

If you maintain a grandfathered health plan as defined under The Patient Protection and Affordable Care Act and you intend to make a change in the contribution rate at any point during the year, you must provide written notice to Aetna 60 days in advance of the effective date of the contribution rate change.

AETNA HEALTH OF CALIFORNIA INC.

EVIDENCE OF COVERAGE

This Evidence of Coverage (“**EOC**”) is part of the Group Agreement (“**Group Agreement**”) between Aetna Health of California Inc., hereinafter referred to as **HMO**, and the **Contract Holder**. The **Group Agreement** determines the terms and conditions of coverage. The **EOC** describes health care benefits. Provisions of this **EOC** include the Schedule of Benefits, any riders and any amendments, endorsements, inserts, or attachments. Amendments, riders or endorsements may be delivered with the **EOC** or added thereafter.

“**HMO**” means Aetna Health of California Inc. a California corporation operating pursuant to Chapter 2.2 of Division 2 of the Health and Safety Code (commencing with Section 1340), commonly known as the Knox-Keene Health Care Service Plan of 1975.

HMO agrees with the **Contract Holder** to provide coverage for benefits, in accordance with the conditions, rights, and privileges as set forth in this **EOC**. **Members** covered under this **EOC** are subject to all the conditions and provisions of the **Group Agreement**. In the event of a conflict between the provisions of the **Group Agreement** and the **EOC**, the **EOC** will prevail.

Coverage is not provided for any services received before coverage starts or after coverage ends, except as shown in the Continuation and Conversion section of this **EOC**. Certain words have specific meanings when used in this **EOC**. The defined terms appear in bold type with initial capital letters. The definitions of those terms are found in the Definitions section of this **EOC**.

This EOC is not in lieu of insurance for Workers’ Compensation. This EOC is governed by applicable federal law and the laws of California.

READ THIS ENTIRE EOC CAREFULLY. IT DESCRIBES THE RIGHTS AND OBLIGATIONS OF MEMBERS AND HMO. IT IS THE CONTRACT HOLDER’S AND THE MEMBER’S RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS EOC.

IN SOME CIRCUMSTANCES, CERTAIN MEDICAL SERVICES ARE NOT COVERED OR MAY REQUIRE PRE-AUTHORIZATION BY HMO.

NO SERVICES ARE COVERED UNDER THIS EOC IN THE ABSENCE OF PAYMENT OF CURRENT PREMIUMS SUBJECT TO THE GRACE PERIOD AND THE PREMIUMS SECTION OF THE GROUP AGREEMENT.

THIS EOC APPLIES TO COVERAGE ONLY AND DOES NOT RESTRICT A MEMBER’S ABILITY TO RECEIVE HEALTH CARE SERVICES THAT ARE NOT, OR MIGHT NOT BE, COVERED BENEFITS UNDER THIS EOC.

PARTICIPATING PROVIDERS, NON-PARTICIPATING PROVIDERS, INSTITUTIONS, FACILITIES OR AGENCIES ARE NEITHER AGENTS NOR EMPLOYEES OF HMO. HMO IS NOT THE AGENT OF ANY PARTICIPATING PROVIDER OR OTHER PROVIDER, INSTITUTION, FACILITY, OR AGENCY. NEITHER HMO NOR THE CONTRACT HOLDER (YOUR EMPLOYER OR GROUP) IS THE AGENT OF EACH OTHER.

A STATEMENT DESCRIBING AETNA HEALTH OF CALIFORNIA INC.’S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO MEMBERS UPON REQUEST.

SOME HOSPITALS AND OTHER PROVIDERS DO NOT PROVIDE ONE OR MORE OF THE FOLLOWING SERVICES THAT MAY BE COVERED UNDER YOUR PLAN CONTRACT AND THAT YOU OR YOUR FAMILY MEMBER MIGHT NEED: FAMILY PLANNING; CONTRACEPTIVE SERVICES, INCLUDING EMERGENCY CONTRACEPTION; STERILIZATION, INCLUDING TUBAL LIGATION AT THE TIME OF LABOR AND DELIVERY; INFERTILITY TREATMENTS; OR ABORTION. YOU SHOULD OBTAIN MORE INFORMATION BEFORE YOU ENROLL. CALL

YOUR PROSPECTIVE DOCTOR, MEDICAL GROUP, INDEPENDENT PRACTICE ASSOCIATION, OR CLINIC, OR CALL THE HEALTH PLAN AT 1-800-756-7039 TO ENSURE THAT YOU CAN OBTAIN THE HEALTH CARE SERVICES THAT YOU NEED.

Important

Unless otherwise specifically provided, no Member has the right to receive the benefits of this plan for health care services or supplies furnished following termination of coverage. Benefits of this plan are available only for services or supplies furnished during the term the coverage is in effect and while the individual claiming the benefits is actually covered by the Group Agreement. Benefits may be modified during the term of this plan as specifically provided under the terms of the Group Agreement or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply for services or supplies furnished on or after the effective date of the modification. There is no vested right to receive the benefits of the Group Agreement.

Contract Holder: The Government of the District of Columbia

Contract Holder Number: 172614

Contract Holder Group Agreement Effective Date: January 1, 2013

TABLE OF CONTENTS

<u>Section</u>	<u>Page</u>
HMO Procedure	4
Fees and Charges	10
Eligibility And Enrollment	11
Covered Benefits	15
Exclusions and Limitations	30
Termination of Coverage	35
Continuation and Conversion	38
Claim Procedures	46
Complaints and Appeals	48
Independent Medical Review	50
Binding Arbitration	52
Limitations on Remedies	53
Coordination of Benefits	54
Effects of Medicare on Coverage Under This EOC	57
Right of Reimbursement Recovery	58
Recovery Rights Related to Workers' Compensation	59
Responsibility of Members	59
General Provisions	59
Definitions	63

HMO PROCEDURE

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

IN SOME CIRCUMSTANCES, CERTAIN MEDICAL SERVICES ARE NOT COVERED OR MAY REQUIRE PREAUTHORIZATION BY HMO.

ELIGIBILITY, COVERED BENEFITS, MEDICAL NECESSITY, PRECERTIFICATION, CONCURRENT REVIEW, RETROSPECTIVE RECORD REVIEW AND ALL OTHER TERMS AND CONDITIONS OF THE MEMBER'S HEALTH PLAN ARE DETERMINED AT THE SOLE DISCRETION OF THE HMO (OR ITS DESIGNEE). THIS MEANS THAT SOME SERVICES RECOMMENDED BY THE MEMBER'S HEALTH PROFESSIONAL MAY NOT BE COVERED BENEFITS AS DETERMINED BY HMO.

A. Selecting a Participating Primary Care Physician.

HMO uses a network of independent **Participating Providers**, comprised of **Physicians, Hospitals** and other **Health Professionals** and facilities throughout the **Service Area**. Certain **PCP** offices are affiliated with Medical Groups (i.e. integrated delivery systems, Independent Practice Associations (IPAs) and Physician-Hospital Organizations), and **Members** who select these **PCPs** will generally be referred to **Specialists** and **Hospitals** within that Medical Group. Each **Primary Care Physician (PCP)** is associated with a **Participating Hospital**. **Members** must use the **Hospital** with which the **Member's Primary Care Physician** is associated except when it is **Medically Necessary** to receive services elsewhere or when obtaining certain direct access **Specialist** benefits as described in this **EOC**.

At the time of enrollment, each **Member** should select a **Participating Primary Care Physician (PCP)** from **HMO's** Directory of **Participating Providers** to access **Covered Benefits** as described in this **EOC**. The choice of a **PCP** is made solely by the **Member**. If the **Member** is a minor or otherwise incapable of selecting a **PCP**, the **Subscriber** should select a **PCP** on the **Member's** behalf. If the **Member** does not select a **PCP** within a reasonable time after being eligible for **Covered Benefits**, **HMO** will designate a **PCP** for the **Member** and notify the **Member** of such selection. The **Member** can change the selection of the **PCP** thereafter. The **PCP** is not an agent or employee of **HMO** and the selection of a **PCP** by **HMO** is merely a convenience for **Members** to assure access to **Covered Benefits**.

PCPs and **Providers** may be paid in any of the following ways: depending upon the type of contract they have with **HMO**.

1. A fixed price per service.
2. A fixed price per day.
3. A fee for each service set by a fee schedule.
4. A fixed monthly amount per **Member**.

Providers contracted with **HMO** have no requirement to comply with specified numbers, targeted averages or maximum duration for patient visits. Compensation arrangements are designed to encourage the provision of the most appropriate care for each **Member** and to discourage the provision of unnecessary, and potentially detrimental services. When **Providers** are paid a fixed monthly amount per **Member**, **HMO** incorporates specific "quality factors" into the compensation process. **Provider** compensation is adjusted based on results in various areas, including: appropriate diagnostic testing, specialty and **Hospital** utilization; **Member** satisfaction survey results; thoroughness of medical chart documentation; clinical care measures for diabetes, asthma and other conditions; number of scheduled office hours; range of office procedures offered; around the clock coverage; and participation in continuing education programs. **Members** are encouraged to ask **Physicians** and other **Providers** how they are compensated in their individual cases, including whether their arrangements include any financial incentives.

B. The Primary Care Physician.

The **PCP** coordinates a **Member's** medical care, as appropriate, either by providing treatment or by issuing **Referrals** to direct the **Member** to another **Participating Provider**. The **PCP** can also order lab tests and x-rays, prescribe medicines or therapies, and arrange hospitalization. Except in a **Medical Emergency**, for **Urgent Care** services received outside the **HMO Service Area** or for certain direct access **Specialist** benefits as described in this **EOC**, only those services which are provided by or referred by a **Member's PCP** will be covered. **Covered Benefits** are described in the **Covered Benefits** section of this **EOC**. It is a **Member's** responsibility to consult with the **PCP** in all matters regarding the **Member's** medical care.

In certain situations where a **Member** requires ongoing care from a **Specialist**, the **Member** may receive a **Standing Referral** to such **Specialist**. Please refer to "Requesting a Standing Referral" in this section for additional information.

If the **Member's PCP** performs, suggests, or recommends a **Member** for a course of treatment that includes services that are not **Covered Benefits**, the entire cost of any such non-covered services will be the **Member's** responsibility.

C. Availability of Providers.

HMO cannot guarantee the availability or continued participation of a particular **Provider** or **Participating Medical Group**. However, changes to the **Provider** network do not affect the **Member's** plan benefits, cost-sharing or **Premiums**. Either **HMO** or any **Participating Provider** may terminate the **Provider** contract or limit the number of **Members** that will be accepted as patients. If the **PCP** initially selected cannot accept additional patients the **Member** will be notified and given an opportunity to make another **PCP** selection. If the **Member** does not select a **PCP** within a reasonable time after being notified they must choose a different **PCP**, **HMO** will designate a **PCP** for the **Member** and notify the **Member** of such selection. The **Member** can change the selection of the **PCP** thereafter. If a **Member's PCP** terminates, the **Member** will be notified of the termination. **Members** must notify the **HMO** of their new choice of **PCP** prior to the date of the **PCP's** termination, or **HMO** will assign a new **PCP** to the **Member**. The **Member** may change their **PCP** selection if they do not wish to utilize the **PCP** assigned to the **Member**. For additional information about the notification process when **PCPs** and other types of **Providers** terminate, the **Member** may refer to the General Provisions section "Independent Contractor Relationship" in this **EOC**.

D. Changing a PCP.

A **Member** may submit a request to change their **PCP** at any time by calling the Member Services toll-free telephone number 1-800-756-7039 or by written or electronic submission of the **HMO's** change form. A **Member** may contact **HMO** to request a change form or for assistance in completing that form. The change will become effective on the 1st or the 15th of the month, or if the **Member** is in an **Active Course of Treatment**, when the change is coordinated between the **Member's** old and new **PCPs**.

E. Ongoing Reviews.

HMO conducts ongoing reviews of those services and supplies which are recommended or provided by **Health Professionals** to determine whether such services and supplies are consistent with established coverage guidelines and therefore are **Covered Benefits** under this **EOC**. In making these decisions **HMO** uses nationally recognized industry guidelines, and internally developed Coverage Policy Bulletins (CPBs). **HMO** reviews new medical technologies (devices, procedures and techniques) and new applications of established technologies to decide whether they are safe and effective and therefore should be **Covered Benefits** when determined to be **Medically Necessary** for a **Member**. **Members** may access the CPBs at the website, www.aetna.com. However, CPBs are technical discussions of available published research, and position statements and clinical practice guidelines of medical associations and government agencies. **Members** are encouraged to discuss CPBs of interest with their **PCP**. If **HMO** determines that the recommended services and supplies are not **Covered Benefits**, the **Member** will be notified. If a **Member**

wishes to appeal such determination, the **Member** may then contact **HMO** to seek a review of the determination. Please refer to the Complaints and Appeals/Independent Medical Review sections of this **EOC**.

The management of a **Member's** healthcare through ongoing reviews employs a consistent set of integrated medical management tools. The process consists of the management of a **Member's Referrals** by the **PCP** to other **Health Professionals**; the review of the **Medical Necessity** and appropriateness of inpatient admissions as well as outpatient tests and procedures; monitoring of inpatient services once admitted; and the transitioning from inpatient to outpatient services. For additional information about this process please contact the **HMO Member Services** at 1-800-756-7039.

Additional information about the timeframes for decisions and notifications of **HMO** decisions regarding Ongoing Reviews is provided in the Claim Procedure section of the **EOC**.

F. Referrals and Pre-Authorization.

Certain services and supplies under this **EOC** may require pre-authorization by **HMO** to determine if they are **Covered Benefits** under this **EOC**.

Member's PCP is responsible for coordinating **Member's** health care, either by treating **Member** directly or by referring **Member** to a **Participating Specialist**. **Members** must contact their **PCP** before seeking **Medical Services** unless the **Member** is seeking **Emergency Services**, **Urgent Care** services outside the **HMO Service Area**, or covered direct access **Specialist** benefits. For all other services, **Member** must first obtain an authorized **Referral** from **Member's PCP**. When **Member** needs a **Specialist**, **Member's PCP** will provide **Member** with an authorized **Referral** to a **Participating Provider** within the **PCP's** associated Medical Group, unless it is **Medically Necessary** to refer **Member** to an **Appropriately Qualified Specialist** outside of the **PCP's** Medical Group. If there is no **Appropriately Qualified Participating Provider** in the network, the **HMO** will authorize a **Referral** to an **Appropriately Qualified Provider** outside the network. For certain services, **Member's PCP** must also obtain pre-authorization from **HMO**. If the **Specialist** visited by **Member** on **Referral** from **Member's PCP** wants to refer **Member** to another **Specialist**, an additional written authorized **Referral** must be obtained. **Member's PCP** may decide to see **Member** again before making a **Referral** to another **Specialist**.

If the **Member's** approved **Referral** is to a nonparticipating **Provider**, services provided pursuant to the **Referral** will be provided at no extra cost to the **Member** beyond what the **Member** would otherwise pay for services received within the **HMO** network of **Participating Providers**.

Additional information about Referrals and pre-authorizations is located in the Covered Benefits sections regarding Mental Health and Substance Abuse.

For additional information regarding the pre-authorization process, **Members** may contact a Member Service Representative at 1-800-756-7039.

Information regarding timeframes for decisions and notification of decisions is located in the Claim Procedure section of the **EOC**.

G. Second Opinion.

Upon request by a **Member**, **HMO** or **Member's PCP** will authorize a second medical opinion regarding a diagnosis, proposed surgery or course of treatment recommended or provided by **Member's PCP** or a **Specialist**. If the **Member** requests a second opinion regarding care provided or recommended by the **PCP**, the second opinion must be obtained from an **Appropriately Qualified Specialist** of the **Member's** choice within the **PCP's** affiliated Medical Group. If the **Member** requests a second opinion regarding care recommended or provided by a **Specialist**, the **Member** must choose an **Appropriately Qualified Specialist** from within the **HMO** network of **Participating Providers**. If there is no **Appropriately Qualified Participating Provider** in the network, the **HMO** will authorize a **Referral** to an

Appropriately Qualified Provider outside the network. To request a second opinion, **Members** should contact their **PCP** for a **Referral**. In cases where access to a second opinion should be expedited due to imminent and serious health threat, **HMO** will respond to **Member's** request for a second opinion within 72 hours of receiving the request. For additional information regarding second opinions including copies of the **HMO's** timelines for responding to requests for second opinions, **Members** may contact Member Services at 1-800-756-7039.

H. **Requesting a Standing Referral.**

Members with (i) a **Life-Threatening or Seriously Debilitating Condition** or (ii) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request that a **Specialist** or **Specialty Care Center** assume responsibility for providing or coordinating the **Member's** medical care, including primary and specialty care. A **Member** may make this request through the **Member's PCP** or **Specialist**. The **Member** or **Physician** will be sent a form to be completed and returned to the **HMO** for review. If **HMO**, or the **PCP**, in consultation with an **HMO** medical director and **Specialist**, if any, determines that the **Member's** care would most appropriately be coordinated by a **Specialist** or **Specialty Care Center**, **PCP** will authorize a **Standing Referral** to such **Specialist** or **Specialty Care Center** for up to 12 months. Such determination will be made within 3 business days of the date that all appropriate medical records and other items of information necessary to make the determination are provided and, once a determination is made the **Referral** shall be issued within 4 business days.

Any authorized **Referral** shall be made pursuant to a treatment plan approved by **HMO** in consultation with the **PCP** (if appropriate), the **Specialist** or **Specialty Care Center**, the **Member** or the **Member's** designee. The approved **Specialist** or **Specialty Care Center** will be permitted to treat the **Member** without further **Referral** from the **Member's PCP** and may authorize such **Referrals**, procedures, tests and other **Medical Services** as the **Member's PCP** would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan. For the purposes of this coverage, a **Specialty Care Center** means only centers that are accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having expertise in treating the **Life-Threatening or Seriously Debilitating Condition** for which it is accredited or designated.

Members will receive **Standing Referrals** to an **Appropriately Qualified Specialist** within the **PCP's** affiliated Medical Group if available, or to an **Appropriately Qualified Participating Specialist**. **HMO** is not required to permit a **Member** to elect to have a **Standing Referral** to a non-participating **Specialist**, unless an **Appropriately Qualified Specialist** is not available within **HMO's** network of **Participating Providers**. If the **Member's** approved **Standing Referral** is to a non-participating **Provider**, services provided pursuant to the approved treatment plan will be provided at no extra cost to the **Member** beyond what the **Member** would otherwise pay for services received within the **HMO** network of **Participating Providers**. **Members** may call Member Services at 1-800-756-7039 for additional information regarding **Appropriately Qualified Participating Specialists**.

I. **Requesting Continuity of Care.**

In order to provide for the transition of **Members** with minimal disruption, **HMO** permits **Members** who meet certain requirements to continue an **Active Course of Treatment** with a terminated or (for new **Members**) a non-participating **Provider** for a transitional period. In the case of new **Members**, benefits will be provided at the new plan benefit level in this **EOC**. Throughout this section "continuation care" refers to the services which the **Member** may be eligible to receive.

The following definitions apply to the Continuity of Care section of this **EOC**:

- **Acute Condition:** A medical or mental health condition that involves a sudden onset of symptoms due to an illness, injury, or other medical or mental health problem that requires prompt medical attention or prompt mental health services and that has a limited duration.

- Serious Chronic Condition: A medical or mental health condition due to a disease, illness, or other medical or mental health problem or disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.
 - Pregnancy (Pregnant): The three trimesters of pregnancy and the immediate postpartum period.
 - Terminal Illness: An incurable or irreversible condition that has a high probability of causing death within one year or less.
1. **Members** who are undergoing an **Active Course of Treatment** are eligible to receive continuation of care as specified below.
 - the **Member** has an Acute Condition, a Serious Chronic Condition, or a Terminal Illness.
 - the **Member** is Pregnant.
 - the **Member** is a child between birth and age 36 months. For purposes of this section well baby/well child care is one kind of **Active Course of Treatment** covered for newborns between birth and age 36 months.
 - the **Member** has received authorization for surgery or other procedure by the plan as part of a documented course of treatment that has been recommended and documented by the **Provider** to occur within 180 days of the **Provider's** termination or within 180 days of the **Member's Effective Date of Coverage** with **HMO**.
 2. The timeframe for completion of **Covered Benefits** is:
 - Acute Condition – for the duration of the Acute Condition.
 - Serious Chronic Condition – for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another **Provider**, as determined by the **HMO** in consultation with the **Member** and the **Provider**, consistent with good professional practice. This time period shall not exceed 12 months from the contract termination date of the terminated **Provider** or 12 months from the **Effective Date of Coverage** for a new **Member**.

 For mental health conditions **HMO** will take into account on a case-by-case basis, the length of the transition period, the severity of the **Member's** condition, and the amount of time reasonably necessary to effect a safe transfer to a **Participating Provider**. Reasonable consideration will be given to the potential clinical effect of a change of **Provider** on the **Member's** treatment for the condition.
 - Pregnancy – for the duration of the Pregnancy and the immediate postpartum period.
 - Terminal Illness – for the duration of the Terminal Illness.
 - Child between the ages of birth and 36 months – shall not exceed 12 months from the contract termination date of the terminated **Provider** or 12 months from the **Effective Date of Coverage** for a new **Member**.
 - Performance of Surgery or Other Procedure - within 180 days of the **Provider's** contract termination date, or 180 days from the **Effective Date of Coverage** for a new **Member**.

3. In order for continuation care to be a **Covered Benefit** under this **EOC** the following conditions must be met:
- The **Member** must be enrolling as a new **Member**, or renewing in a different Aetna Health of California Inc. plan that has a different provider network, or a current **Member** receiving an **Active Course of Treatment** from a terminated provider. If the other requirements listed in this section are met **Members** and their current treating **Providers** may request continuing coverage according to the conditions of this Continuity of Coverage section;
 - **Members** are *not* eligible for continuing care if their coverage under this **EOC** includes the Non-Referred Benefits Rider;
 - **Member** must be eligible for continuation care as described in item number 1 above;
 - The **Member** must have begun an **Active Course of Treatment** prior to **Effective Date of Coverage** with the new plan, or prior to the date the formerly **Participating Provider** was terminated;
 - The terminated **Provider** must have terminated their contract with the **HMO** or been terminated by **HMO** for reasons other than medical disciplinary action, fraud or other criminal activity;
 - The transition request must be submitted to **HMO** within 90 days after the enrollment or re-enrollment period, or within 90 days from the date of discontinuation of the **Provider's** contract and prior to receiving services (except in an emergency) from the non-participating **Provider**; and
 - If services are received prior to the approval of transition of benefits, the services must be approved by **HMO** Medical Director in order for coverage to be extended at the new benefit plan level.
4. In order for a **Provider** to continue treating **HMO Members** during a transition period, the **Provider** must agree in writing to:
- provide or continue to provide the **Member's** treatment and follow-up care;
 - share or continue to share information regarding the treatment plan with **HMO**;
 - use or continue to use **HMO** network for any necessary **Referrals**, diagnostic tests or procedures or hospitalizations;
 - accept or continue to accept **HMO** capitation rates and/or similar fee schedules as other non-capitated **Providers** in the same geographic area for similar services; and in the case of a terminated **Provider** to;
 - continue to abide by the terms and conditions of the prior contract.

Members may request a copy of the Transition of Care Coverage Policy and the "Transition Coverage Request Form" at the time of enrollment in the new plan or by calling the member services telephone number listed on their ID card and requesting the policy (which includes the form as an attachment). The **Member** fills out and submits the Transition Coverage Request Form within the time frames described above. This continuity of care provision shall not be construed to require **HMO** to provide coverage for services not otherwise covered by **HMO** under this **EOC**. **Members** whose requests for Transition of Care Coverage are denied may file a

grievance with the plan, in accordance with the Claim Procedures/Complaints and Appeals/External Independent Medical Review section of the **EOC**.

J. Facilities.

Member's selection of a **Primary Care Physician** also determines the **Hospital** to which **Member** will be admitted unless it is **Medically Necessary** to receive **Hospital** services elsewhere.

A provider directory listing **Participating Physicians** and their affiliated Medical Groups, **Hospitals**, laboratories, pharmacies, **Skilled Nursing Facilities**, home health agencies and other ancillary health care and subacute facilities will be distributed to **Members**. If another copy of the directory is needed, a **Member** may call the **Contract Holder** or **HMO** member services at 1-800-756-7039. The list of **Participating Providers** is subject to change.

K. Liability of Member for Payment.

All non-Emergency Services or Urgent Care services must be provided by **Member's Primary Care Physician**, **Member's PCP's** on-call **Physician**, or a **Participating Provider** referred by **Member's PCP** except for certain direct access **Specialist** benefits as described in the **EOC**.

If **Member** seeks care, other than covered direct access **Specialist** benefits, from a **Provider** other than **Member's PCP** without a **Referral**, **HMO** will not pay the costs. Coverage for services of a **Physician** or other **Health Professional** who is not a **Participating Provider** requires prior authorization before the service or supply is obtained, except for **Emergency Services** or **Urgent Care** services received outside the **HMO Service Area**. If **HMO** denies payment to a non-**Participating Provider**, **Member** will be liable to the **Provider** for the cost of services.

HMO's contracts with its **Participating Providers** specify that, except for **Copayments**, **Members** are not liable for payment for **Medically Necessary Covered Benefits** which have the appropriate pre-authorization, even if **HMO** fails to pay the **Participating Provider**.

FEES AND CHARGES

A. Premiums.

Contract Holder is responsible for advance payment of **Premiums** for **HMO** coverage in accordance with the **Group Agreement**. **Members** may be required to pay a portion of such premiums. If so, **Members** will be notified by **Contract Holder**.

Coverage is only provided for **Members** whose **Premiums** have been received by **HMO**. Coverage extends only for the period for which such payment is received, subject to any allowances stated in the **Group Agreement**.

B. Copayments.

Member will be required to make certain **Copayments** for **Covered Benefits** as specified in the Schedule of Benefits. **Copayments** must be paid at the time the **Covered Benefits** are rendered. The total aggregate amount of **Copayments** a **Member** is required to pay per year for basic services is specified in the Schedule of Benefits.

Member will also be responsible for any charges made by **Participating Providers** for scheduled appointments that are missed without notice to the **Participating Providers** or without good cause. Personal administrative service costs such as copying **Member** medical records or completing forms for school, camp, employment, etc. are also **Member's** responsibility.

C. **Maximum Out-of-Pocket Limit.**

If a **Member's Copayments** reach the Maximum Out-of-Pocket Limit set forth on the **HMO** Schedule of Benefits, **HMO** will pay 100% of the contracted charges for **Covered Benefits** for the remainder of that **calendar year**. **Covered Benefits** must be rendered to the **Member** during that **calendar year**.

ELIGIBILITY AND ENROLLMENT

A. **Eligibility.**

1. To be eligible to enroll as a **Subscriber**, an individual must:
 - a. meet all applicable eligibility requirements agreed upon by the **Contract Holder** and **HMO**; and
 - b. live or work in the **Service Area**.
2. To be eligible to enroll as a **Covered Dependent**, the **Contract Holder** must provide dependent coverage for **Subscribers**, and the dependent must be:
 - a. the legal spouse or domestic partner of a **Subscriber** of the same or opposite sex; or
 - b. the domestic partner of a **Subscriber** under this **EOC**. A domestic partner of a **Subscriber** is a person, as of the date of enrollment, who, with the **Subscriber**, has executed and filed a Declaration of Domestic Partnership with the Secretary of State, or with the **Subscriber**:
 - provides proof of cohabitation (e.g. driver's license or tax return);
 - is of the age of consent in the state of residence;
 - is not related by blood in any manner that would bar marriage in the state of residence;
 - has a close, committed and monogamous personal relationship;
 - has been sharing the same household on a continuous basis for at least 6 months;
 - has registered as a domestic partner where such registration is available;
 - is not married to, or separated from, another individual;
 - has not been registered as a member of another domestic partnership within the last 6 months; andprovides proof of three or more of the following:
 - common ownership of real property or a common leasehold interest in such property;
 - common ownership of a motor vehicle;
 - joint bank accounts or credit accounts;
 - designation as a beneficiary for life insurance or retirement benefits, or under the partner's will;
 - assignment of a durable power of attorney or health care power of attorney; or
 - such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case; and
 - is of the same or opposite sex as the **Subscriber**.
 - c. A dependent unmarried child (including natural, foster, step, legally adopted children, children placed for adoption, a child under court order) who meets the eligibility requirements described on the Schedule of Benefits.

3. A **Member** who resides outside the **Service Area** is required to choose a **PCP** and return to the **Service Area** for **Covered Benefits**. The only services covered outside the **Service Area** are **Emergency Services** and **Urgent Care**.

B. Enrollment.

Unless otherwise noted, an eligible individual and any eligible dependents may enroll in **HMO** regardless of health status, age, or requirements for health services within 31 days from the eligibility date.

1. Newly Eligible Individuals and Eligible Dependents.

An eligible individual and any eligible dependents may enroll within 31 days of the eligibility date.

2. Open Enrollment Period.

Eligible individuals or dependents who are eligible for enrollment but do not enroll as stated above, may be enrolled during any subsequent **Open Enrollment Period** upon submission of complete enrollment information and **Premium** payment to **HMO**.

3. Enrollment of Newly Eligible Dependents.

- a. Newborn Children.

A newborn child is covered for 31 days from the date of birth. To continue coverage beyond this initial period, the child must be enrolled in **HMO** within the initial 31-day period. If coverage does not require the payment of an additional **Premium** for a **Covered Dependent**, the **Subscriber** must still enroll the child within 31 days after the date of birth.

The coverage for newly born, adopted children, and children placed for adoption consists of coverage of injury and sickness, including the necessary care and treatment of congenital defects and birth abnormalities, and within the limits of this **EOC**. Coverage includes necessary transportation costs from place of birth to the nearest specialized **Participating** treatment center.

- b. Adopted Children.

A legally adopted child or a child for whom a **Subscriber** is a court appointed legal guardian, and who meets the definition of a **Covered Dependent**, will be treated as a dependent from the date of adoption or upon the date the child was placed for adoption with the **Subscriber**. "Placed for adoption" means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The **Subscriber** must make a written request for coverage within 31 days of the date the child is adopted or placed with the **Subscriber** for adoption.

4. Special Rules Which Apply to Children.

- a. Qualified Medical Child Support Order.

Coverage is available for a dependent child not residing with a **Subscriber** and who resides outside the **Service Area**, if there is a qualified medical child support order requiring the **Subscriber** to provide dependent health coverage for a non-resident child. The child must meet the definition of a **Covered Dependent**, and the **Subscriber** must make a written request for coverage within 31 days of the court order.

b. Physically and Mentally Disabled Children.

Coverage is available for a child who is chiefly dependent upon the **Subscriber** for support and maintenance, and who is 19 years of age or older but incapable of self-support due to a physical or mental disability, injury, illness or condition as long as the physical or mental disability, injury, illness or condition started prior to the age the dependent would have lost eligibility.

The **HMO** will send a notice to the **Subscriber** at least 90 days before the child reaches the limiting age that the dependent child's coverage will end unless proof of the child's physical or mental disability, injury, illness or condition is received within 60 days of receiving the notice of proof.

The **HMO** will make a determination as to whether the dependent child is entitled to continue coverage before the child reaches the limiting age. However, if the **HMO** fails to make the necessary determination by the time the child reaches the limiting age, coverage will continue pending the determination of continued eligibility due to the physical or mental disability, injury, illness or condition.

Thereafter, proof of continued physical or mental disability, injury, illness or condition, including a medical examination, must be submitted to **HMO** as requested, but not more frequently than annually beginning after the two-year period following the date the physically or mentally disabled child attains the age specified on the Schedule of Benefits.

This eligibility provision will no longer apply on the date the dependent's physical or mental disability injury, illness or condition ends.

5. Notification of Change in Status.

It shall be a **Member's** responsibility to notify **HMO** of any changes which affect the **Member's** coverage under this **EOC**, **unless a different notification process is agreed to between HMO and Contract Holder**. Such status changes include, but are not limited to, change of address, change of **Covered Dependent** status, and enrollment in Medicare or any other group health plan of any **Member**. Additionally, if requested, a **Subscriber** must provide to **HMO**, within 31 days of the date of the request, evidence satisfactory to **HMO** that a dependent meets the eligibility requirements described in this **EOC**.

6. Special Enrollment Period.

An eligible individual and eligible dependents may be enrolled during a Special Enrollment Period. A Special Enrollment Period may apply when an eligible individual or eligible dependent loses other health coverage or when an eligible individual acquires a new eligible dependent through marriage, birth, adoption or placement for adoption.

Special Enrollment Period for Certain Individuals Who Lose Other Health Coverage:

An eligible individual or an eligible dependent may be enrolled during a Special Enrollment Period, if the following requirements, as applicable, are met:

- a. the eligible individual or the eligible dependent was covered under another group health plan or other health insurance coverage when initially eligible for coverage under **HMO**; or
- b. the eligible individual or eligible dependent previously declined coverage in writing under **HMO**.

In addition, **one** of the following items must also apply:

- the eligible individual or eligible dependent becomes eligible for State premium assistance in connection with coverage under **HMO**; or
- the eligible individual or eligible dependent loses coverage under the other group health plan or other health insurance coverage for **one** of the following reasons:
 - i. the other group health coverage is COBRA continuation coverage under another plan, and the COBRA continuation coverage under that other plan has since been exhausted; or
 - ii. the other coverage is a group health plan or other health insurance coverage, and the other coverage has been terminated as a result of loss of eligibility for the coverage or employer contributions towards the other coverage have been terminated; or
 - iii. the other health insurance coverage is Medicaid or an S-Chip plan and the eligible individual or eligible dependent no longer qualifies for such coverage.

Loss of eligibility includes the following:

- a loss of coverage as a result of legal separation, divorce or death;
- termination of employment;
- reduction in the number of hours of employment;
- in the case of the Healthy Families Program, exceeding the program's income or age limits;
- any loss of eligibility after a period that is measured by reference to any of the foregoing;
- termination of **HMO** coverage due to **Member** action/movement outside of the **HMO's** service area; and also the termination of health coverage including Non-HMO, due to plan termination;
- plan ceases to offer coverage to a group of similarly situated individuals;
- cessation of a dependent's status as an eligible dependent;
- termination of benefit package.

Loss of eligibility does not include a loss due to failure of the individual or the participant to pay **Premiums** on a timely basis or due to termination of coverage for cause as referenced in the Termination of Coverage section of this **EOC**.

To be enrolled in **HMO** during a Special Enrollment Period, the eligible individual or eligible dependent must enroll within:

- a. 31 days, beginning on the date of the eligible individual's or eligible dependent's loss of other group health plan or other health insurance coverage; or
- b. 60 days, beginning on the date the eligible individual or eligible dependent
 - (i) becomes eligible for premium assistance in connection with coverage under **HMO**, or
 - (ii) is no longer qualified for coverage under Medicaid or S-Chip.

The **Effective Date of Coverage** will be the first day of the first calendar month following the date the completed request for enrollment is received.

The eligible individual or the eligible dependent enrolling during a special enrollment period will not be subject to late enrollment provisions, if any, described in this **EOC**.

Special Enrollment Period When a New Eligible Dependent is Acquired

When a new eligible dependent is acquired through marriage, birth, adoption or placement for adoption, the new eligible dependent (and, if not otherwise enrolled, the eligible individual and other eligible dependents) may be enrolled during a special enrollment period.

The special enrollment period is a period of 31 days, beginning on the date of the marriage, birth, adoption or placement for adoption (as the case may be). If a completed request for enrollment is made during that period, the **Effective Date of Coverage** will be:

- In the case of marriage, the first day of the first calendar month following the date the completed request for enrollment is received.
- In the case of a dependent's birth, adoption or placement for adoption, the date of such birth, adoption or placement for adoption.

The eligible individual or the eligible dependent enrolling during a special enrollment period will not be subject to late enrollment provisions, if any, described in this **EOC**.

C. Effective Date of Coverage.

Coverage shall take effect at 12:01 a.m. on the **Member's** effective date. Coverage shall continue in effect from month to month subject to payment of **Premiums** made by the **Contract Holder** and subject to the Termination section of the **Group Agreement** and the Termination of coverage section of this **EOC**.

Hospital Confinement on Effective Date of Coverage.

If a **Member** is an inpatient in a **Hospital** on the **Effective Date of Coverage**, the **Member** will be covered as of that date. Such services are not covered if the **Member** is covered by another health plan on that date and the other health plan is responsible for the cost of the services. **HMO** will not cover any service that is not a **Covered Benefit** under this **EOC**. To be covered, the **Member** must utilize **Participating Providers** and is subject to all the terms and conditions of this **EOC**.

D. Renewal Provisions

If **Contract Holder** has renewed the **Group Agreement**, **Members** still eligible for coverage under this **HMO** may renew coverage under the same **Group Agreement**, if all **Premiums** have been properly paid and the **Member** meets the eligibility requirements. Such annual renewal is automatic and reapplication is not necessary. **Premiums** may change upon renewal. If coverage for **Subscriber** and **Covered Dependents** is terminated, **Subscriber** must submit a new application.

COVERED BENEFITS

A **Member** shall be entitled to the **Covered Benefits** as specified below, in accordance with the terms and conditions of this **EOC**. Unless specifically stated otherwise, in order for benefits to be covered, they must be **Medically Necessary**. For the purpose of coverage, **HMO** may determine whether any benefit provided under the **EOC** is **Medically Necessary**, and **HMO** has the option to only authorize coverage for a **Covered Benefit** performed by a particular **Provider**. Preventive care, as described below, will be considered **Medically Necessary**.

ALL SERVICES ARE SUBJECT TO THE EXCLUSIONS AND LIMITATIONS DESCRIBED IN THIS **EOC**.

Use of the term “**Medically Necessary**” in this **EOC** is referring to health care services and supplies or prescription drugs that a **Physician** or other health care provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating a condition or an illness, injury, disease or its symptoms is:

- (a) In accordance with generally accepted standards of medical or health care practice;
- (b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s condition, illness, injury or disease;
- (c) Not primarily for the convenience of the patient, **Physician** or other health care provider; and
- (d) 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 that patient’s condition, illness, injury, or disease.

In determining if a service or supply is **Medically Necessary**, **HMO’s** Patient Management Medical Director or its **Physician** designee will consider:

- information provided on the **Member’s** health status;
- reports in peer-reviewed medical literature;
- reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;
- the opinion of **Health Professionals** in the generally recognized health specialty involved;
- the opinion of the attending **Physicians**, which have credence but do not overrule contrary opinions; and
- any other relevant information brought to **HMO’s** attention.

All **Covered Benefits** will be covered in accordance with the guidelines determined by **HMO**.

If a **Member** has questions regarding coverage under this **EOC**, the **Member** may call Member Services at 1-800-756-7039.

THE MEMBER IS RESPONSIBLE FOR PAYMENT OF THE APPLICABLE COPAYMENTS LISTED ON THE SCHEDULE OF BENEFITS.

EXCEPT FOR DIRECT ACCESS SPECIALIST BENEFITS OR IN A MEDICAL EMERGENCY OR URGENT CARE SITUATION AS DESCRIBED IN THIS EOC, THE FOLLOWING BENEFITS MUST BE ACCESSED THROUGH THE PCP’S OFFICE THAT IS SHOWN ON THE MEMBER’S IDENTIFICATION CARD, OR ELSEWHERE UPON PRIOR REFERRAL ISSUED BY THE MEMBER’S PCP.

A. Primary Care Physician Benefits.

- 1. Office visits during office hours.
- 2. Home visits.
- 3. After-hours **PCP** services. **PCPs** are required to provide or arrange for on-call coverage 24 hours a day, 7 days a week. If a **Member** becomes sick or is injured after the **PCP’s** regular office hours, the **Member** should:
 - a. call the **PCP’s** office; and
 - b. identify himself or herself as a **Member**; and
 - c. follow the **PCP’s** or covering **Physician’s** instructions.

If the **Member's** injury or illness is a **Medical Emergency**, the **Member** should follow the procedures outlined under the Emergency Care/Urgent Care Benefits section of this **EOC**.

4. Hospital visits.
5. Periodic health evaluations to include:
 - a. well-child care from birth including immunizations and booster doses of all immunizing agents used in child immunizations which conform to the standards of the Advisory Committee on Immunization Practices of the Centers for Disease Control, U.S. Department of Health and Human Services. Screening tests for blood lead levels of a **Covered Dependent** child at risk for lead poisoning are also covered.
 - b. routine physical examinations, including, 1) services related to the diagnosis, treatment and appropriate management of osteoporosis and 2) the screening and diagnosis of prostate cancer, including but not limited to, prostate-specific antigen testing and digital rectal examinations, when **Medically Necessary** and consistent with good medical practice.
 - c. routine gynecological examinations, including Pap smears and related laboratory services, for routine care, administered by the **PCP**. The **Member** may also go directly to a **Participating** gynecologist without a **Referral** for routine GYN examinations and Pap smears. See the Direct Access **Specialist** Benefits section of this **EOC** for a description of these benefits.
 - d. routine hearing screenings.
 - e. immunizations (but not if solely for the purpose of travel or employment).
 - f. annual routine vision screenings for the purpose of determining vision loss.
 - g. human papilloma virus (HPV) screening but only if the type of screening test selected and administered has been approved by the U.S. Food and Drug Administration.
6. Injections, including allergy desensitization injections.
7. Casts and dressings.
8. Health Education Counseling and Information, including health education services and guidance, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services.

B. Diagnostic Services Benefits.

Services include, but are not limited to, the following:

1. Diagnostic, laboratory, and x-ray services.
2. Mammograms, by a **Participating Provider**. The **Member** is required to obtain a **Referral** from her **PCP** or gynecologist, or obtain pre-authorization from **HMO** to a **Participating Provider**, prior to receiving this benefit.

Screening mammogram benefits for female **Members** are provided as follows:

- ages 35 to 39, one baseline mammogram;
- age 40 and older, one routine mammogram every year; or

- when **Medically Necessary**.
3. **Medically Necessary** cancer screening tests which are generally accepted by the **Medical Community**.

C. **Specialist Physician Benefits.**

Covered Benefits include outpatient and inpatient services.

D. **Direct Access Specialist Benefits.**

The following services are covered without a **Referral** when rendered by a **Participating Provider** other than the **Member's PCP**. The **Member** must select a **Participating** gynecologist or obstetrician in her **PCP's** Medical Group or IPA.

- Routine Gynecological Examination(s). Routine gynecological visit(s), Pap smear(s) and Human Papilloma Virus screening(s). The maximum number of visits, if any, is listed on the Schedule of Benefits.
- Direct Access to Gynecologists. Benefits are provided to female **Members** for services performed by a **Participating** gynecologist for diagnosis and treatment of gynecological problems.

Routine Eye Examinations are covered as shown below without a **Referral** when rendered by a **Provider** identified in the Provider Directory as participating in the Direct Access Eye program.

- Routine Eye Examinations, including refraction, as follows:
 - a. if **Member** is age 1 through 18 and wears eyeglasses or contact lenses, 1 exam(s) every 12-month period.
 - b. if **Member** is age 19 and over and wears eyeglasses or contact lenses, 1 exam(s) every 24-month period.
 - c. if **Member** is age 1 through 45 and does not wear eyeglasses or contact lenses, 1 exam(s) every 36-month period.
 - d. if **Member** is age 46 and over and does not wear eyeglasses or contact lenses, 1 exam(s) every 24-month period.

Subluxation Benefits. Services by a **Participating Provider** when **Medically Necessary** are covered. Services must be consistent with **HMO** guidelines for spinal manipulation to correct a muscular skeletal problem or subluxation which could be documented by diagnostic x-rays performed by an **HMO Participating** radiologist. Coverage is subject to the maximum number of visits, if any, shown on the Schedule of Benefits. A **Copayment**, an annual maximum out-of-pocket limit, and an annual maximum benefit may apply to this service. Refer to the Schedule of Benefits attached to this **EOC**.

E. **Maternity Care and Related Newborn Care Benefits.**

Outpatient and inpatient pre-natal and postpartum care and obstetrical services provided by **Participating Providers** are a **Covered Benefit**, including prenatal genetic testing of a fetus associated with high risk pregnancies, and voluntary participation in the Expanded Alpha Feto Protein (AFP) program, which is a California statewide prenatal testing program administered by the State Department of Health Services.

The **Participating Provider** is responsible for obtaining any required pre-authorizations for all non-routine obstetrical services from **HMO** after the first prenatal visit.

Coverage does not include routine maternity care received while outside the **Service Area** unless the **Member** receives pre-authorization from **HMO**. Coverage for **Emergency Services**, including **Active Labor** and **Urgent Care** is described in Emergency Services/Urgent Care Benefits.

As an exception to the **Medically Necessary** requirements of this **EOC**, the following coverage is provided for a mother and newly born child:

1. a minimum of 48 hours of inpatient care in a **Participating Hospital** following a vaginal delivery;
2. a minimum of 96 hours of inpatient care in a **Participating Hospital** following a cesarean section;
or
3. a shorter **Hospital** stay, if requested by a mother, and if determined to be medically appropriate by the **Participating Providers** in consultation with the mother.

If a **Member** requests a shorter **Hospital** stay, the **Member** will be covered for one home health care visit scheduled to occur within 24 hours of discharge. An additional visit will be covered when prescribed by the **Participating Provider**. This benefit is in addition to the home health maximum number of visits, if any, shown on the Schedule of Benefits. A **Copayment** will not apply for home health care visits.

F. **Inpatient Hospital and Skilled Nursing Facility Benefits.**

A **Member** is covered for services only at **Participating Hospitals** and **Participating Skilled Nursing Facilities** except in a **Medical Emergency**, as outlined under the Emergency Care/Urgent Care Benefits section of this **EOC**. All services are subject to pre-authorization by **HMO**. In the event that the **Member** elects to remain in the **Hospital** or **Skilled Nursing Facility** after the date that the **Participating Provider** and/or the **HMO** Medical Director has determined and advised the **Member** that the **Member** no longer meets the criteria for continued inpatient confinement, the **Member** shall be fully responsible for direct payment to the **Hospital** or **Skilled Nursing Facility** for such additional **Hospital**, **Skilled Nursing Facility**, **Physician** and other **Provider** services, and **HMO** shall not be financially responsible for such additional services.

Inpatient **Hospital** cardiac and pulmonary rehabilitation services are covered by **Participating Providers** upon **Referral** issued by the **Member's PCP** and pre-authorization by **HMO**.

Coverage for **Skilled Nursing Facility** benefits is subject to the maximum number of days, if any, shown on the Schedule of Benefits.

G. **Transplant Benefits.**

Transplants which are non-experimental or non-investigational are a **Covered Benefit**. Transplants which are **Experimental or Investigational** may be covered if approved in advance by **HMO**. For additional information about the criteria and process for approval of **Experimental and Investigational** transplants call member Services at 1-800-756-7039. The Complaints and Appeals and Independent Medical Review sections of this **EOC** provide additional information regarding the **Member's** right to appeal and Independent Medical Review of **HMO** decisions that a proposed transplant is **Experimental or Investigational**.

Once it has been determined that a **Member** may require a **Transplant**, the **Member** or the **Member's Physician** must call the **HMO** precertification department to discuss coordination of the **Transplant** process. Non-experimental or non-investigational **Transplants** coordinated by **HMO** and performed at an

Institute of Excellence, (IOE), are Covered Benefits. The **IOE** facility must be specifically approved and designated by **HMO** to perform the **Transplant** required by the **Member**.

Covered Benefits include the following when provided by an **IOE**.

- Inpatient and outpatient expenses directly related to a **Transplant Occurrence**.
- Charges made by a **Physician** or **Transplant** team.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an “immediate” family member is defined as a first-degree biological relative. These are your biological parent, sibling or child.
- Charges for activating the donor search process with national registries.
- Charges made by a **Hospital** or outpatient facility and/or **Physician** for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the **IOE** facility during the **Transplant Occurrence** process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; **Home Health Services** and home infusion services.

One **Transplant Occurrence** includes the following four phases of **Transplant** care:

1. **Pre-Transplant Evaluation/Screening:** Includes all **Transplant**-related professional and technical components required for assessment, evaluation and acceptance into a **Transplant** facility’s **Transplant** program.
2. **Pre-Transplant/Candidacy Screening:** Includes HLA typing of immediate family members.
3. **Transplant Event:** Includes inpatient and outpatient services for all **Transplant**-related health services and supplies provided to a **Member** and donor during the one or more surgical procedures or medical therapies for a **Transplant**; prescription drugs provided during the **Member’s** inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during the **Member’s** inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement.
4. **Follow-up Care:** Includes **Home Health Services**; home infusion services; and **Transplant**-related outpatient services rendered within 365 days from the date of the **Transplant**.

For the purposes of this section, the following will be considered to be one **Transplant Occurrence**:

- Heart
- Lung
- Heart/ Lung
- Simultaneous Pancreas Kidney (SPK)
- Pancreas
- Kidney
- Liver
- Intestine
- Bone Marrow/Stem Cell **Transplant**
- Multiple organs replaced during one **Transplant** surgery
- Tandem **Transplants** (Stem Cell)
- Sequential **Transplants**
- Re-**Transplant** of same organ type within 365 days of the first **Transplant**
- Any other single organ **Transplant**, unless otherwise excluded under the coverage.

The following will be considered to be more than one **Transplant Occurrence**:

- Autologous Blood/Bone Marrow **Transplant** followed by Allogenic Blood/Bone Marrow **Transplant** (when not part of a tandem **Transplant**)
- Allogenic Blood/Bone Marrow **Transplant** followed by an Autologous Blood/Bone Marrow **Transplant** (when not part of a tandem **Transplant**)
- Re-**Transplant** after 365 days of the first **Transplant**
- Pancreas **Transplant** following a kidney **Transplant**

- A **Transplant** necessitated by an additional organ failure during the original **Transplant** surgery/process.
- More than one **Transplant** when not performed as part of a planned tandem or sequential **Transplant**, (e.g. a liver **Transplant** with subsequent heart **Transplant**).

H. **Outpatient Surgery Benefits.**

Coverage is provided for outpatient surgical services and supplies in connection with a covered surgical procedure when furnished by a **Participating** outpatient surgery center. All services and supplies are subject to pre-authorization by **HMO**.

I. **Substance Abuse Benefits.**

The diagnosis and **Medically Necessary** inpatient and outpatient treatment of a **Substance Abuse** are covered under the same terms and conditions as any other medical condition.

A **Member** is covered for the following services as authorized and provided by **Participating Behavioral Health Providers**:

- Outpatient care benefits are covered for **Detoxification**. Benefits include diagnosis, medical treatment and medical referral services (including referral services for appropriate ancillary services) by the **Member's PCP** for the abuse of or addiction to alcohol or drugs.

Member is entitled to outpatient visits to a **Participating Behavioral Health Provider** upon **Referral** by the **PCP** for diagnostic, medical or therapeutic **Substance Abuse Rehabilitation** services. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.

- Inpatient care benefits are covered for **Detoxification**. Benefits include medical treatment and referral services for **Substance Abuse** or addiction. The following services shall be covered under inpatient treatment: lodging and dietary services; **Physicians**, psychologist, nurse, certified addictions counselor and trained staff services; diagnostic x-ray; psychiatric, psychological and medical laboratory testing; and drugs, medicines, equipment use and supplies.

Member is entitled to medical, nursing, counseling or therapeutic **Substance Abuse Rehabilitation** services in an inpatient, **Hospital** or non-hospital **Residential Treatment Facility**, appropriately licensed by the Department of Health, upon referral by the **Member's Participating Behavioral Health Provider** for alcohol or drug abuse or dependency. The **Residential Treatment Facility** must also meet any and all applicable licensing standards established by the jurisdiction in which it is located. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.

J. **Mental Health Benefits.**

The diagnosis and **Medically Necessary** inpatient and outpatient treatment of a **Mental Illness** (including **Serious Emotional Disturbances of a Child**) are covered under the same terms and conditions as any other medical condition.

A **Member** is covered for treatment of a **Mental Illness** (including **Serious Emotional Disturbances of a Child**) through **Participating Behavioral Health Providers**.

- Outpatient benefits are covered for outpatient evaluative and crisis intervention or home health mental health services, and are subject to the maximums, if any, shown on the Schedule of Benefits.
- Inpatient benefits may be covered for medical, nursing, counseling or therapeutic services in an inpatient, **Hospital** or non-hospital **Residential Treatment Facility**, appropriately licensed by the

Department of Health or its equivalent. The **Residential Treatment Facility** must also meet any and all applicable licensing standards established by the jurisdiction in which it is located. Coverage, if applicable, is subject to the maximums, if any, shown on the Schedule of Benefits.

K. **Emergency Services/Urgent Care Benefits.**

1. A **Member** is covered for **Emergency Services**, provided the service is a **Covered Benefit**, and **HMO's** medical review determines that the **Member's** symptoms were such that a prudent layperson, possessing average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the **Member's** health, or with respect to a pregnant **Member**, the health of the woman and her unborn child.

The **Copayment** for an emergency room visit as described on the Schedule of Benefits will not apply either in the event that the **Member** was referred for such visit by the **Member's PCP** for services that should have been rendered in the **PCP's** office or if the **Member** is admitted into the **Hospital**.

The **Member** will be reimbursed for the cost for **Emergency Services** rendered by a non-participating **Provider** located either within or outside the **HMO Service Area**, for those expenses, less **Copayments**, which are incurred up to the time the **Member** is determined by **HMO** and the attending **Physician** to be medically able to travel or to be transported to a **Participating Provider**. In the event that transportation is **Medically Necessary**, the **Member** will be reimbursed for the cost as determined by **HMO**, minus any applicable **Copayments**. Reimbursement may be subject to payment by the **Member** of all **Copayments** which would have been required had similar benefits been provided during office hours and upon prior **Referral** to a **Participating Provider**.

Medical transportation is covered during a **Medical Emergency** if the **Member** reasonably believed that the medical condition was a **Medical Emergency** and reasonably believed that the condition required ambulance transport services.

Members are encouraged to appropriately use the 911 emergency response system when a **Medical Emergency** requires emergency response. If the situation is not a **Medical Emergency** please call your **PCP** for instructions. Your **PCP** is required to provide coverage 24 hours a day, including weekends and holidays.

2. **Urgent Care.**

Urgent Care Within the HMO Service Area. If the **Member** needs **Urgent Care** while within the **HMO Service Area**, but the **Member's** illness, injury or condition is not serious enough to be a **Medical Emergency**, the **Member** should first seek care through the **Member's PCP**. If the **Member's PCP** is not reasonably available to provide services for the **Member**, the **Member** may access **Urgent Care** from a **Participating Urgent Care** facility within the **HMO Service Area**.

Urgent Care Outside the HMO Service Area. The **Member** will be covered for **Urgent Care** obtained from a **Physician** or licensed facility outside of the **HMO Service Area** if the **Member** is temporarily absent from the **HMO Service Area** and receipt of the health care service cannot be delayed until the **Member** returns to the **HMO Service Area**.

A **Member** is covered for any follow-up care. Follow-up care is any care directly related to the need for **Emergency Services** or **Urgent Care** which is provided to a **Member** after the **Medical Emergency** or **Urgent Care** situation has terminated. All follow-up and continuing care must be provided or arranged by a **Member's PCP**. The **Member** must follow this procedure, or the **Member** will be responsible for payment for all follow-up services received.

L. **Rehabilitation Benefits.**

The following benefits are covered when **Medically Necessary**, provided by **Participating Providers** upon **Referral** issued by the **Member's PCP** and pre-authorized by **HMO**.

1. Cardiac rehabilitation benefits are available as part of a **Member's** inpatient **Hospital** stay. A limited course of outpatient cardiac rehabilitation is covered when **Medically Necessary** following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
2. Pulmonary rehabilitation benefits are available as part of a **Member's** inpatient **Hospital** stay. A limited course of outpatient pulmonary rehabilitation is covered when **Medically Necessary** for the treatment of reversible pulmonary disease states.
3. Cognitive therapy for medical conditions is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy based upon a written treatment plan that supports the **Member's** ability to progress toward the treatment goals. The treatment plan is coordinated with **HMO**.

Cognitive therapy is also covered for behavioral health conditions provided the therapy is **Medically Necessary**.

Coverage is subject to the limits, if any, shown on the Schedule of Benefits. For inpatient cognitive therapy benefits refer to the **Inpatient Hospital and Skilled Nursing Facility** benefit provisions under the **Covered Benefits** section of this **Evidence of Coverage**.

4. Physical therapy is covered to diagnose and treat physical and mental health conditions based upon a written treatment plan that supports the **Member's** ability to progress toward the treatment goals. The treatment plan is coordinated with **HMO**. Coverage is subject to the limits, if any, shown on the Schedule of Benefits. For inpatient physical therapy benefits refer to the **Inpatient Hospital and Skilled Nursing Facility** benefit provisions under the **Covered Benefits** section of this **Evidence of Coverage**.
5. Occupational therapy is covered to diagnose and treat physical and mental health conditions based upon a written treatment plan that supports the **Member's** ability to progress toward the treatment goals. The treatment plan is coordinated with **HMO**. Coverage is subject to the limits, if any, shown on the Schedule of Benefits. For inpatient physical the occupational benefits refer to the **Inpatient Hospital and Skilled Nursing Facility** benefit provisions under the **Covered Benefits** section of this **Evidence of Coverage**.
6. Speech therapy is covered to diagnose and treat physical and mental health conditions including, but not limited to the diagnosis and treatment of speech difficulties that occur as a result of a **Severe Mental Illness** or **Serious Emotional Disturbances of a Child** based upon a written treatment plan that supports the **Member's** ability to progress toward the treatment goals. The treatment plan is coordinated with **HMO**. Services rendered for the treatment of delays in speech development, unless to diagnose and treat physical and mental health conditions, are not covered. Coverage is subject to the limits, if any, shown on the Schedule of Benefits. For inpatient speech therapy benefits refer to the **Inpatient Hospital and Skilled Nursing Facility** benefit provisions under the **Covered Benefits** section of this **Evidence of Coverage**.
7. Additional rehabilitation benefits beyond the limits, if any, shown on the Schedule of Benefits may be approved by the **HMO** if the Medical Director determines that the services in 3, 4, 5, or 6 above, when directed and monitored by a **Participating Provider**, when medical documentation supports the **Member's** ability to progress toward the treatment goals.

M. **Home Health Benefits.**

The following services are covered for a **Homebound Member** when provided by a **Participating** home health care agency. Pre-authorization must be obtained from the **HMO** by the **Member's** attending **Participating Physician**. **HMO** shall not be required to provide home health benefits when **HMO** determines the treatment setting is not appropriate, or when there is a more cost-effective setting in which to provide covered health care services. Coverage for **Home Health Services** is not determined by the availability of caregivers to perform the services; the absence of a person to perform a non-skilled or **Custodial Care** service does not cause the service to become covered. If the **Member** is a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), coverage for **Home Health Services** will only be provided during times when there is a family member or caregiver present in the home to meet the **Member's** non-skilled needs. Coverage is subject to the maximum number of visits, if any, shown on the Schedule of Benefits.

Skilled Nursing services that require the medical training of and are provided by a licensed nursing professional are a covered benefit. Services must be provided during intermittent visits of 4 hours or less with a daily maximum of 3 visits. Up to 12 hours (3 visits) of continuous **Skilled Nursing** services per day within 30 days of an inpatient **Hospital** or **Skilled Nursing Facility** discharge may be covered, when all home health care criteria are met, for transition from the **Hospital** or **Skilled Nursing Facility** to home care. Services are subject to the limits, if any, listed in the Outpatient Home Health Visits section of the Schedule of Benefits.

Skilled home behavioral health care provides intermittent skilled services for treatment of behavioral disorders in the home. These services are rendered in lieu of hospitalization, confinement in a **Skilled Nursing Facility**, or going outside of the home for the service. **HMO** considers provision of skilled behavioral health services in the home **Medically Necessary** when all of the following conditions are met:

- The services are ordered by a **Participating Provider** and are directly related to an active treatment plan of care established by the **Participating Provider**; *and*
- The skilled behavioral health care is appropriate for the active treatment of a physical or mental condition to avoid placing the **Member** at risk for serious complications; *and*
- The skilled behavioral health care is intermittent or hourly in nature; *and*
- The services are provided in lieu of a continued hospitalization, confinement in a residential or rehabilitation facility (RTF), or receiving outpatient services outside of the home; *and*
- The treatment provided is appropriate for the **Member's** condition including the amount of time spent providing the service as well as the frequency, type and duration of the services; *and*
- The **Member** is homebound because of a physical or mental condition (i.e., the **Member** leaves home only with considerable and taxing effort and absences from home are infrequent, or of short duration, or to receive medical care); *and*
- The behavioral health services provided are not for the comfort or convenience of the **Member** or custodial in nature.

Services of a home health aide are covered only when they are provided in conjunction with **Skilled Nursing** services and directly support the **Skilled Nursing**. Services must be provided during intermittent visits of 4 hours or less with a daily maximum of 3 visits. Services are subject to the limits, if any, listed in the Outpatient Home Health Visits section of the Schedule of Benefits.

Medical social services are covered only when they are provided in conjunction with **Skilled Nursing** services and must be provided by a qualified social worker.

Outpatient home health short-term physical, speech, or occupational therapy is covered when the above home health care criteria are met. Coverage is subject to the conditions and limits listed in the Outpatient Rehabilitation Benefit section of the **Evidence of Coverage** and the Outpatient Rehabilitation section of the Schedule of Benefits.

Covered **Home Health Care** benefits do not include charges for infusion therapy.

N. **Hospice Benefits.**

Hospice Care services for a terminally ill **Member** are covered when pre-authorized by **HMO**. Services may include home and **Hospital** visits by nurses and social workers; pain management and symptom control; instruction and supervision of a family **Member**; inpatient care; counseling, including bereavement counseling and emotional support; and other home health benefits listed in the Home Health Benefits section of this **EOC**.

Nursing care services are covered on a continuous basis during periods of crisis as necessary to maintain **Member** at home. Homemaker or home health aide services may be covered, but the care provided must be predominantly nursing care. A period of crisis is a period in which the **Member** requires continuous care to achieve palliation or management of acute medical symptoms. Hospitalization will be covered if **Skilled Nursing** care is required at a level that cannot be provided in the home.

Respite care will be provided only when necessary to relieve the family members or other persons caring for the **Member**. Coverage of respite care will be limited to an occasional basis and to no more than five consecutive days at a time.

Coverage is not provided for funeral arrangements, pastoral counseling, financial or legal counseling. Except as needed to maintain **Member** at home during periods of crisis, homemaker or caretaker services, and any service not solely related to the care of the **Member**, including but not limited to, sitter or companion services for the **Member** or other **Members** of the family, transportation, house cleaning, and maintenance of the house are not covered.

O. **Prosthetic and Orthotic Appliances.**

The **Member's** initial provision or **Medically Necessary** replacement of a prosthetic device or custom fitted orthotics that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease or injury or congenital defects is covered, when such device is prescribed by a **Participating Provider**, administered through a **Participating** or designated prosthetic **Provider**, and pre-authorized by **HMO**. This benefit includes the provision of prosthetic devices a) to restore and achieve symmetry incident to a mastectomy due to diagnosed breast cancer or other breast disease or, b) subsequent to a laryngectomy. Coverage does not include electronic voice producing machines. Coverage includes repair and replacement when due to congenital growth. Instruction and appropriate services required for the **Member** to properly use the item (such as attachment or insertion) are covered. Covered prosthetic appliances include those items covered by Medicare unless excluded in the Exclusions and Limitations section of this **EOC**. **HMO** reserves the right to provide the most cost efficient and least restrictive level of service or item which can be safely and effectively provided.

P. **Injectable Medications Benefits.**

Medically Necessary Injectable medications, including those medications intended to be self-administered, are a **Covered Benefit**. Medications must be prescribed by a **Provider** licensed to prescribe federal legend prescription drugs or medicines, and pre-authorized by **HMO**. If the drug therapy treatment is approved for self-administration, the **Member** is required to obtain covered medications at an **HMO Participating** pharmacy designated to fill injectable prescriptions except in **Medical Emergency** or **Urgent Care** situations.

Injectable drugs or medication used for the treatment of cancer or HIV are covered when the off-label use of the drug has not been approved by the FDA for that indication, provided that such drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) and the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer-reviewed journal.

Q. **Mastectomy and Reconstructive Breast Surgery Benefits.**

Coverage for a mastectomy shall include a) coverage for all complications from a mastectomy including **Medically Necessary** physical therapy to treat the complications of mastectomy, including lymphedema, b) prosthetic devices, or c) reconstruction of the breast on which the mastectomy is performed including areolar reconstruction and the insertion of a breast implant and surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed.

The length of **Hospital** stay for mastectomies and lymph node dissections shall be determined by the attending **Physician** and surgeon in consultation with the patient and consistent with sound clinical practices.

R. **Reconstructive Surgery Benefits.**

Reconstructive Surgery, performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease is covered when:

1. pre-authorization is requested by the **Member's PCP** in consultation with the **Member's Specialist** and approved by **HMO**;
2. the requested surgery will improve function or create a normal appearance to the extent possible;
3. there is no more appropriate surgical procedure which will be approved for the **Member**;
4. the proposed surgery or surgeries offer more than a minimal improvement in the appearance of the **Member**.

Pre-authorization decisions, including determining whether **Reconstructive Surgery** will produce more than a minimal improvement in the appearance of the **Member**, shall be made by an **HMO Medical Director** or delegate who is a licensed **Physician** competent to evaluate the specific clinical issues involved in the care requested, based upon the standards of care practiced by **Physicians** specializing in the type of reconstructive surgery. This means, for example, that for a treatment request submitted by a podiatrist or an oral and maxillofacial surgeon, the request will be reviewed by a similarly licensed individual, competent to evaluate the specific clinical issues involved in the care requested.

S. **Limited General Anesthesia for Dental Procedures.**

General anesthesia and associated facility charges for dental procedures rendered in a hospital or surgery center are covered when:

1. pre-authorized by **HMO**;
2. the clinical status or underlying medical condition of the **Member** requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital or surgery center; and
3. the **Member** for whom the treatment is proposed
 - a. is under seven years of age, or
 - b. is developmentally disabled, regardless of age, or
 - c. has a health condition which makes the general anesthesia **Medically Necessary**, regardless of age.

Coverage does not include charges for the dental procedure itself, including, but not limited to, the professional fees of the dentist. Coverage is subject to the applicable **Copayments** for applicable services, if any, listed in the Schedule of Benefits.

T. **Diabetes Treatment.**

Treatment, education for outpatient self-management, and equipment and supplies are covered when **Medically Necessary**. Coverage includes, but is not limited to:

1. Diabetic daycare self-management and education programs, provided by appropriately licensed participating **Health Care Professionals**. Training shall include self-management training, education, and medical nutrition therapy necessary to enable **Members** to properly use the equipment, supplies, and medications prescribed or referred by the **Member's Participating Provider**.
2. Diabetic equipment, supplies and medications:
 - a. Insulin,
 - b. Prescriptive medications for the treatment of diabetes,
 - c. Glucagon,
 - d. Blood glucose monitors and blood glucose testing strips,
 - e. Blood glucose monitors designed to assist the visually impaired,
 - f. Insulin pumps and all related necessary supplies,
 - g. Ketone urine testing strips,
 - h. Lancets and lancet puncture devices,
 - i. Pen delivery systems for the administration of insulin,
 - j. Podiatric devices to prevent or treat diabetes-related complications,
 - k. Insulin syringes,
 - l. Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

If coverage under this **EOC** includes a Prescription Drug Rider, the medications and supplies listed in the Prescription Drug Rider will be covered under the Prescription Drug Rider. **Copayments** for these medications and supplies are shown on the Prescription Drug Rider.

U. **Phenylketonuria Benefit.**

In addition to coverage for the testing and treatment of Phenylketonuria (PKU), coverage for treatment of Phenylketonuria includes those formulas and special food products that are part of a diet prescribed by a **Participating Provider** and managed by a **Health Care Professional** in consultation with a **Participating Specialist** who specializes in metabolic disease to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU. For purposes of this section, "special food product" means a food product that is prescribed by the **Member's Participating Provider** and used in place of normal food products used by the general population. "Special food product" does not include foods that are naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving.

Refer to the Schedule of Benefits for applicable copayments. A **Copayment** and a maximum annual out-of-pocket payment, may apply to this service.

V. **Temporomandibular Joint Syndrome (TMJ) Services.**

Coverage for the treatment for temporomandibular joint dysfunction shall include pre-authorized **Medically Necessary** surgical procedures. Dental procedures, including but not limited to, the extraction of teeth and orthodontic devices and splints are excluded unless covered under a Rider attached to this **EOC**.

W. **Durable Medical Equipment Benefits.**

Durable Medical Equipment will be provided when pre-authorized by **HMO**. The wide variety of **Durable Medical Equipment** and continuing development of patient care equipment makes it impractical

to provide a complete listing; therefore, the **HMO** Medical Director has the authority to approve requests on a case-by-case basis. Covered **Durable Medical Equipment** includes those items covered by Medicare unless excluded in the Exclusions and Limitations section of this **EOC**. **HMO** reserves the right to provide the most cost-efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **HMO**.

Instruction and appropriate services required for the **Member** to properly use the item, such as attachment or insertion, are also covered upon pre-authorization by **HMO**. Replacement, repairs and maintenance are covered only if it is demonstrated to the **HMO** that:

1. it is needed due to a change in the **Member's** physical condition; or
2. it is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment.

All maintenance and repairs that result from a misuse or abuse are a **Member's** responsibility.

A Copayment, an annual maximum out-of-pocket payment limit, and an annual maximum benefit may apply to this service. Refer to the Schedule of Benefits attached to this **EOC**.

X. Additional Benefits.

- **Clinical Cancer Trials, Phase I, II, III or IV.**

As an exception to the exclusion of treatments determined to be **Experimental or Investigational**, routine health care services are covered for **Members** whose treating **Provider** determines that a clinical cancer trial has a meaningful potential to benefit the **Member** and recommends participation. The clinical trial must involve a drug that is exempt under federal regulations from a new drug application and approved by the National Institute of Health, the FDA, the US Department of Defense or the Veteran's Administration. Routine health care services include the provision of drugs, items, devices and services which would be **Covered Benefits** if provided other than in connection with an approved clinical trial program, including health care services which are:

- a. typically provided absent a clinical trial;
- b. required solely for the provision of the investigational drug, item, device, or service;
- c. required for the clinically appropriate monitoring of the investigational item or service; or;
- d. provided for the prevention or treatment of complications arising from the provision of the investigational drug, item device, or service.

Routine health care services do not include:

- a. drugs or devices that have not been approved by the federal Food and Drug Administration and that are associated with the clinical trial;
- b. travel, housing, companion expenses, and other non-clinical expenses that a **Member** may require as a result of the treatment being provided in the clinical trial;
- c. items or services provided solely to satisfy data collection and analysis and not used in the clinical management of the patient;
- d. services that are not **Covered Benefits** under the plan, if provided other than as part of the clinical trial; and
- e. services customarily provided free of charge for participants in the clinical trial.

The **HMO** may restrict coverage for clinical trials to **Participating Hospitals** and **Physicians** in California unless the protocol for the clinical trial is not provided for a California **Hospital** or by a California **Physician**.

The copayments applied to services delivered in a clinical trial will be the same as those applied to the same services if not delivered in a clinical trial.

- **Basic Infertility Services Benefits.**

Benefits include only those **Infertility** services provided to a **Member**: a) by a **Participating Provider** to diagnose **Infertility**; and b) by a **Participating Infertility Specialist** to surgically treat the underlying cause of **Infertility**.

- **Infusion Therapy Benefits.**

Infusion Therapy is the intravenous or continuous administration of medications or solutions that are **Medically Necessary** for the **Member's** course of treatment. The following outpatient Infusion Therapy services and supplies are covered for a **Member** when provided by a **Participating Provider**:

- the pharmaceutical when administered in connection with Infusion Therapy and any medical supplies, equipment and nursing services required to support the Infusion Therapy;
- professional services;
- total parenteral nutrition (TPN);
- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives).

Coverage is subject to the maximums, if any, shown on the Schedule of Benefits.

Inpatient infusion therapy is provided under the Inpatient Hospital and Skilled Nursing Facility Benefits section of the Covered Benefits section of the **EOC**.

Except due to an emergency or for **Urgent Care** while the **Member** is outside of the **Service Area**, coverage for Infusion Therapy benefits is only provided when rendered by **Participating Providers**.

Benefits payable for Infusion Therapy will not count toward any applicable **Home Health Care** maximums.

- **Orthotic and Prosthetic Devices.**

Orthotic and Prosthetic Devices are covered when:

- prescribed by a **Physician** (including a surgeon and podiatrist); or
- ordered by any other licensed health care provider acting within the scope of his or her license.

Covered benefits include, but are not limited to, charges made for:

- the initial devices such as an artificial limb, hand, or foot; and
- the initial devices and the installation accessories, to restore a method of speaking for the covered person following a laryngectomy; and
- special footwear when needed due to foot disfigurements including disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes, and foot disfigurement caused by accident or developmental disability.

Also included are the repair and/or replacement of an orthotic or prosthetic device. The device will only be replaced if:

- There is change in your physical condition; or normal growth or wear and tear; or

- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

EXCLUSIONS AND LIMITATIONS

A. Exclusions.

The following are not **Covered Benefits** except as described in the Covered Benefits section of this **EOC** or by a rider and/or an amendment attached to this **EOC**:

- Ambulance services, for routine transportation to receive outpatient or inpatient services.
- Biofeedback, except as pre-authorized by **HMO** based upon **Medical Necessity**. **HMO** considers biofeedback to be **Medically Necessary** for the following conditions:
 - Urinary incontinence;
 - Migraine and tension headaches (muscle, thermal or skin biofeedback; EEG biofeedback is considered experimental and investigational for this indication);
 - Temporomandibular joint (TMJ) syndrome;
 - Neuromuscular rehabilitation of stroke and traumatic brain injury (TBI);
 - Fecal incontinence;
 - Raynaud's disease;
 - Chronic constipation;
 - Irritable bowel syndrome;
 - Refractory severe subjective tinnitus; and
 - Levator ani syndrome.
- Care furnished to provide a safe surrounding in the **Member's** home (except as provided in the **Home Health Care Benefits** section under **Covered Benefits**), including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- Certain **Transplant Occurrence**-related services or supplies including: treatment furnished to a donor when the **Transplant** recipient is not a **Member**; services and supplies not obtained from an **IOE**, including the harvesting or storage of organs without the expectation of immediate transplantation for an existing illness; harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness; outpatient prescription drugs not expressly related to an outpatient **Transplant Occurrence**; and home infusion therapy.
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) **Transplants** unless authorized by **HMO**. **Members** may appeal non-authorization decisions and may request independent medical review according to the provisions of the Complaints and Appeals section of the **EOC**.
- **Cosmetic Surgery**, or other services intended primarily to improve the **Member's** appearance or treatment relating to the consequences of, or as a result of, **Cosmetic Surgery**. This exclusion does not apply to:
 - **Medically Necessary** reconstructive surgery as described in the Covered Benefits sections, Mastectomy and Reconstructive Breast Surgery or Reconstructive Surgery;
 - surgery to correct the results of injuries causing an impairment;
 - surgery as a continuation of a staged reconstruction procedure, including but not limited to post-mastectomy reconstruction;
 - surgery to correct congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate;
 - **Medically Necessary** services directly related to **Cosmetic Surgery** when complications exceed routine follow-up care.

- Court ordered services, or those required by court order as a condition of parole or probation.
- **Custodial Care. Please Note:** A **Member** receiving custodial care is also entitled to receive **Medically Necessary** basic health care services.
- Dental services including but not limited to, services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, dental services related to the gums, apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, alveolectomy, augmentation and vestibuloplasty, treatment of periodontal disease, false teeth, prosthetic restoration of dental implants, and dental implants. This exclusion does not apply to:
 - removal of bony impacted teeth, bone fractures, removal of tumors, and biopsy or excision of oral cysts.
 - **Emergency Services** to stabilize an acute injury to sound natural teeth, the jawbone or surrounding structures, if provided within 48 hours of the injury.
 - surgical treatment of TMJ as described in the Covered Benefits Section, “**Temporomandibular Joint Syndrome (TMJ) Services**”.
 - Dental anesthesia when provided according to the conditions described in the Covered Benefits Section, “Limited General Anesthesia for Dental Procedures”.
- Educational services for treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders including developmental and learning disorders associated with mental retardation, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, learning disabilities, or developmental delays. Special education, including lessons in sign language to instruct a **Member**, whose ability to speak has been lost or impaired, to function without that ability, are not covered. This exclusion does not apply to **Serious Emotional Disturbances of a Child** and/or **Severe Mental Illness** as defined in the Definitions section of this EOC. **Medically Necessary** diagnosis and treatment for **Pervasive Developmental Disorders** or autism is covered as **Severe Mental Illness** and/or **Serious Emotional Disturbances of a Child** including, but not limited to Physical Therapy, Occupational Therapy and Speech Therapy.
- **Experimental or Investigational Procedures**, or ineffective surgical, medical, psychiatric, or dental treatments or procedures, research studies, or other experimental or investigational health care procedures or pharmacological regimes as determined by **HMO**, unless pre-authorized by **HMO**. The Complaints and Appeals and Independent Medical Review sections of the EOC describe the process by which a **Member** may appeal **HMO’s** decision to deny coverage based on this exclusion.

This exclusion will not apply with respect to drugs:

1. that have been granted treatment investigational new drug (IND) or Group c/treatment IND status;
 2. that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or
 3. **HMO** has determined that available scientific evidence demonstrates that the drug is effective or the drug shows promise of being effective for the disease.
- Hair analysis.
 - Hearing aids.
 - Home births.
 - Home uterine activity monitoring.

- Household equipment, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses or waterbed, whirlpool or swimming pools, exercise and massage equipment, central or unit air conditioners, air purifiers, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a **Member's** house or place of business, and adjustments to vehicles.
- Hypnotherapy, except when pre-authorized by **HMO** based on **Medical Necessity**.
- The treatment of male or female **Infertility**, including but not limited to:
 1. The purchase of donor sperm and any charges for the storage of sperm;
 2. The purchase of donor eggs and any charge associated with care of the donor required for donor egg retrievals or transfers or gestational carriers;
 3. Charges associated with cryopreservation or storage of cryopreserved embryos (e.g., office, **Hospital**, ultrasounds, laboratory tests, etc.);
 4. Home ovulation prediction kits;
 5. Injectable **Infertility** medications, including but not limited to, menotropins, hCG, GnRH agonists, IVIG;
 6. Artificial Insemination, including in vitro fertilization (IVF), gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), and intracytoplasmic sperm injection (ICSI), and any advanced reproductive technology ("ART") procedures or services related to such procedures;
 7. Any charges associated with care required for ART (e.g., office, **Hospital**, ultrasounds, laboratory tests, etc.);
 8. Donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
 9. Any charge associated with a frozen embryo transfer including but not limited to thawing charges;
 10. Reversal of sterilization surgery; and
 11. Any charges associated with obtaining sperm for ART procedures.

This exclusion is superseded by either the Comprehensive Infertility Rider or ART Rider if included in **Member's** plan documents.

- Missed appointment charges.
- Non-medically necessary services, including but not limited to, those services and supplies:
 1. which are not **Medically Necessary**, as determined by **HMO**, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services;
 2. that do not require the technical skills of a medical, mental health or a dental professional;
 3. furnished mainly for the personal comfort or convenience of the **Member**, or any person who cares for the **Member**, or any person who is part of the **Member's** family, or any **Provider**;
 4. furnished solely because the **Member** is an inpatient on any day in which the **Member's** disease or injury could safely and adequately be diagnosed or treated while not confined;
 5. furnished solely because of the setting if the service or supply could safely and adequately be furnished in a **Physician's** or a dentist's office or other less costly setting.

This exclusion does not apply to services or supplies found to be **Medically Necessary** through the Independent Medical Review Process. See the Complaints and Appeals section for additional information regarding Independent Medical Review.

- Orthotics and Orthopedic shoes or other supportive devices except as described in the Orthotic and Prosthetic Devices portion of the **Covered Benefits** section.
- Outpatient supplies (except diabetic supplies), including but not limited to, outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings, and reagent strips.
- Payment for that portion of benefits for which Medicare or a third party payer is the primary payer except that as the secondary payer, **HMO** will pay for **Medically Necessary** basic health care services such as speech and other therapies to treat **Members** with autism notwithstanding of any federal or state requirement that rehabilitation services be provided.
- Personal comfort or convenience items, including those services and supplies not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other like items and services.
- Prescription or non-prescription drugs and medicines, except as provided as an inpatient for purposes of receiving **Covered Benefits** in a **Hospital, Skilled Nursing Facility, Non-Hospital Facility** or in an outpatient surgical procedure facility. Outpatient prescription drugs may be covered by a Rider to this **Evidence of Coverage**.
- Private duty nursing (*See the **Home Health Benefits** section regarding coverage of nursing services*).
- Recreational, educational, and sleep therapy except that:
 - As to recreational and educational therapy: This exclusion does not apply to **Medically Necessary** basic health care required to be covered by **HMO** including, but not limited to, physical, occupational and speech therapy provided under a written treatment plan that supports the **Member's** ability to progress toward treatment goals.
 - As to sleep therapy: This exclusion does not apply to **Medically Necessary** treatment of sleeping disorders.
- Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling, and sex therapy.
- Reversal of voluntary sterilizations, including related follow-up care and treatment of complications of such procedures.
- Routine foot/hand care, including routine reduction of nails, calluses and corns.
- Services for the treatment of sexual dysfunctions or inadequacies, including therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Services, including those related to pregnancy, rendered before the effective date or after the termination of the **Member's** coverage, unless coverage is continued under the Continuation and Conversion section of this **EOC**.
- Services obtained by or on behalf of a **Member** without **Referral** issued by the **Member's PCP** or pre-authorized by **HMO** as explained in the **HMO** Procedure, Referrals and Pre-Authorization

section of this **EOC**. This exclusion does not apply in a **Medical Emergency**, in an **Urgent Care** situation, or when it is a direct access benefit.

- Services performed by a relative of a **Member** for which, in the absence of any health benefits coverage, no charge would be made.
- Services required by third parties, including but not limited to, physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state, or federal government, securing insurance coverage, travel, school admissions or attendance, including examinations required to participate in athletics, except when such examinations are considered to be part of an appropriate schedule of wellness services.
- Specific non-standard allergy services and supplies when not **Medically Necessary**. Examples of non-standard allergy services and supplies include but are not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
- Special medical reports, including those not directly related to treatment of the **Member**, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
- Surgical operations, procedures or treatment of obesity, except when pre-authorized by **HMO**.
- Therapy or rehabilitation, unless **Medically Necessary**, including but not limited to, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, vision perception training, and carbon dioxide.
- Thermograms and thermography, unless determined to be **Medically Necessary**.
- Transsexual surgery, sex change or transformation, including any procedure or treatment or related service designed to alter a **Member's** physical characteristics from the **Member's** biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.
- Treatment in a federal, state, or governmental entity, including care and treatment provided in a non-participating **Hospital** owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws. However, **HMO** will pay for **Medically Necessary** basic health care services such as speech and other therapies to treat **Members** with autism notwithstanding any federal or state requirement that rehabilitation services be provided.
- Treatment of occupational injuries and occupational diseases, including those injuries that arise out of (or in the course of) any work for pay or profit, or in any way result from a disease or injury which does. If a **Member** is covered under a Workers' Compensation law or similar law, and submits proof that the **Member** is not covered for a particular disease or injury under such law, that disease or injury will be considered "non-occupational" regardless of cause. The **Covered Benefits** under this **EOC** for **Members** eligible for Workers' Compensation are not designed to duplicate any benefit to which they are entitled under Workers' Compensation Law. All sums payable for Workers' Compensation services provided under this **EOC** shall be payable to, and retained by **HMO**. Each **Member** shall complete and submit to **HMO** such consents, releases, assignments and other documents reasonably requested by **HMO** in order to obtain or assure reimbursement under the Workers' Compensation Law.
- Vision care services and supplies, including orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) and radial keratotomy, including related procedures designed to surgically correct refractive errors except as provided in the **Covered Benefits** section of this **EOC**.

- Vocational rehabilitation for the purpose of attaining skills needed to obtain or retrain for employment such as telephone skills, etc.
- Weight reduction programs, or dietary supplements, except as pre-authorized by **HMO** for the **Medically Necessary** treatment of morbid obesity.
- Acupuncture except when performed by a **Participating Provider** as a form of anesthesia in connection with covered surgery.
- Temporomandibular joint disorder treatment (TMJ) including treatment performed by prosthesis placed directly on the teeth except as covered in the **Covered Benefits** Section.

B. Limitations.

- In the event there are 2 or more alternative **Medical Services** which in the sole judgment of **HMO** are equivalent in quality of care, **HMO** reserves the right to provide coverage only for the least costly **Medical Service**, as determined by **HMO**, provided that **HMO** approves coverage for the **Medical Service** or treatment in advance. **Members** may appeal **HMO** determinations as explained in the Complaints and Appeals and Independent Medical Review sections of this **EOC**.
- Determinations regarding eligibility for benefits, coverage for services, benefit denials and all other terms of this **EOC** are at the sole discretion of **HMO**, subject to the terms of this **EOC**. Determinations as to coverage for services and benefits will be made based upon **Medical Necessity** consistent with commonly accepted clinical practice guidelines. **Members** may appeal **HMO** determinations as explained in the Complaints and Appeals and Independent Medical Review sections of this **EOC**.

DETERMINATIONS REGARDING DENIAL OF BENEFITS DUE TO INAPPROPRIATE USE OF THE HMO NETWORK ARE AT THE SOLE DISCRETION OF THE HMO.

TERMINATION OF COVERAGE

A **Member's** coverage under this **EOC** will terminate upon the earliest of any of the conditions listed below.

A. Termination of Subscriber Coverage.

A **Subscriber's** coverage will terminate for any of the following reasons:

1. employment terminates;
2. the **Group Agreement** terminates for the following reasons:
 - the **Contract Holder** notifies **HMO** that they wish to terminate the **Group Agreement**;
 - if the **Contract Holder** no longer has any **Subscribers** who live or work in the **Service Area**;
 - upon 90 days' notice if **HMO** ceases to offer the product purchased through the **Group Agreement**; (In compliance with California Law, **HMO** will make its other products offered in the **Service Area** available to the **Contract Holder**);
 - upon 180 days' notice if **HMO** exits the California market entirely.
3. the **Subscriber** is no longer eligible as outlined on the Schedule of Benefits; or
4. the **Subscriber** becomes covered under an alternative health benefit plan or under any other plan which is offered by, through, or in connection with, the **Contract Holder** in lieu of coverage under this **EOC**.

B. Termination of Dependent Coverage.

A **Covered Dependent's** coverage will terminate for any of the following reasons:

1. a **Covered Dependent** is no longer eligible, as outlined in the Eligibility and Enrollment section of the **EOC** or in the Schedule of Benefits;
2. the **Group Agreement** terminates; or
3. the **Subscriber's** coverage terminates.

C. Termination For Cause.

HMO may terminate coverage for cause:

1. upon 15 days' advance written notice of cancellation, if the **Member** has failed to make any required **Premium** payment which the **Member** is obligated to pay, as specified by **Contract Holder**. Only **Members** covered under COBRA or Cal-COBRA continuation coverage are required to make **Premium** payments to **HMO**. Please see the Continuation and Conversion section of this **EOC** for additional information regarding termination under COBRA or Cal-COBRA continuation.
2. within 30 days following the date the **Member** receives a certified letter from the **HMO** upon discovering a material misrepresentation by the **Member** in applying for or obtaining coverage or benefits under this **EOC** or discovering that the **Member** has committed fraud against **HMO**. This may include, but is not limited to, furnishing incorrect or misleading information to **HMO**, or allowing or assisting a person other than the **Member** named on the identification card to obtain **HMO** benefits. In the absence of fraud or material misrepresentation, all statements made by any **Member** or any person applying for coverage under this **EOC** will be deemed representations and not warranties. No statement made for the purpose of obtaining coverage will result in the termination of coverage or reduction of benefits unless the statement is contained in writing and signed by the **Member**, and a copy of same has been furnished to the **Member** prior to termination.
3. upon 15 days' advance written notice of cancellation, if a **Member threatens** the safety of **HMO** employees, **Providers**, **Members**, or other patients, or if the **Member's** repeated behavior has substantially impaired the **HMO's** ability to furnish or arrange services for the **Member** or other **Members**, or substantially impaired a **Provider's** ability to provide services to other patients.
4. upon termination of the **Group Agreement** if the **Contract Holder** has failed to make any **Premium** payments within the grace period specified in the **Group Agreement**. **HMO will** provide written notice of cancellation to **Contract Holder** at least 15 days prior to the date of termination of the **Group Agreement**. The notice will include the date and time of the termination, information regarding Conversion Coverage or HIPAA Individual Coverage, and notice that the **Member** may call Member Services at 1-800-756-7039 to verify that the **Contract Holder** has, or has not paid the required **Premium**. **Contract Holder** will promptly mail a legible, true copy of the notice of cancellation to each **Subscriber** at the **Subscriber's** current address. In addition, **Members** will receive a notice confirming termination of coverage if the **Contract Holder** fails to remit the **Premium** payments within the specified grace period.
5. within 30 days following the date the **Contract Holder** receives a certified letter from the **HMO** if **Contract Holder** has performed any act or practice that constitutes fraud or made any intentional misrepresentation of a material fact relevant to the coverage provided under the **Group Agreement**.
6. upon 30 days' written notice of cancellation to **Contract Holder** if **Contract Holder** (i) breaches a provision of the **Group Agreement** and such breach remains uncured at the end of the notice period; (ii) ceases to meet **HMO's** requirements for an employer group; (iii) fails to meet **HMO's**

contribution or participation requirements applicable to the **Group Agreement** (which contribution and participation requirements are available upon request); (iv) fails to provide the certification required by the **Group Agreement** within a reasonable period of time specified by **HMO**; or (v) changes its eligibility or participation requirements without **HMO's** consent.

D. Disenrollment by Member

If **Member** elects coverage under an alternative health benefits plan offered by or through **Contract Holder** as an option to coverage under **HMO**, **Member's** coverage terminates automatically at the time and date the alternate coverage becomes effective. **Member** and **Contract Holder** agree to notify **HMO** immediately that coverage has been elected elsewhere.

Members may voluntarily disenroll from **HMO**. **Member** may disenroll by notifying **Contract Holder** and/or **HMO** in writing of **Member's** intent to cancel **Membership**. **Member's** coverage terminates at midnight on the last day of the month during which **HMO** receives notice of intent to disenroll, or at midnight on the last day of the month for which **Member** requested cancellation.

E. Effective Date of Termination.

Coverage as a **Member** ceases on the following dates:

1. At midnight on the last day of the month in which **Member** was eligible for coverage according to the eligibility requirements as specified in the Eligibility and Enrollment section of the **EOC** and in the Schedule of Benefits.
2. At midnight on the termination date specified in the written notice of cancellation.
3. On the termination date and time established by **HMO** and **Contract Holder** as specified in the **Group Agreement** or as otherwise agreed by **Contract Holder**.
4. At the time replacement coverage, as provided by the **Contract Holder**, or chosen by the **Member** takes effect.

HMO shall have no further liability or responsibility under this **EOC** except for coverage for **Covered Benefits** provided prior to the date of termination of coverage.

The fact that **Members** are not notified by the **Contract Holder** of the termination of their coverage due to the termination of the **Group Agreement** shall not deem the continuation of a **Member's** coverage beyond the date coverage terminates.

F. Member's Right to Review.

A **Member** may register a **Complaint** with **HMO**, as described in the Claim Procedures/Complaints and Appeals section of this **EOC**, after receiving notice that **HMO** has or will terminate the **Member's** coverage as described in the Termination For Cause subsection of the **EOC**. **HMO** will continue the **Member's** coverage in force until a final decision on the **Complaint** is rendered, provided the **Premium** is paid throughout the period prior to the issuance of that final decision.

Coverage will not be terminated on the basis of a **Member's** health status or health care needs, nor because a **Member** has exercised the **Member's** rights under the **EOC's** Claim Procedures/Complaints and Appeals section to register a **Complaint** with **HMO**. If a **Member** believes their membership was terminated because of the **Member's** health status or requirements for health care services, the **Member** may request a review by the Director of the California Department of Managed Health Care. The **Complaint** process described in the preceding paragraph applies only to those terminations affected pursuant to the Termination for Cause subsection of this **EOC**.

CONTINUATION AND CONVERSION

Members with questions concerning HIPAA may contact the Centers for Medicare & Medicaid Services (CMS) (formerly HCFA) at the following telephone number 1-800-633-4227. CMS has posted at its web site a publication entitled: “Commonly Asked Questions and Answers for Consumers about the Provisions of Health Insurance Portability and Accountability Act of 1996” at the following Internet address: <http://www.hcfa.gov/regs/hipaacer.htm>. CMS may be contacted directly, by mail, at: Centers for Medicare & Medicaid Services, Attention: HIPAA Unit, 75 Hawthorne Street, Suite 401, San Francisco, CA 94105.

A. **Continued Group Coverage (COBRA and Cal-COBRA).**

Members may continue group health coverage under certain circumstances where coverage would otherwise terminate (“continuation coverage”). The Federal law pertaining to this coverage is the Consolidated Omnibus Budget Reconciliation Act (“COBRA”). COBRA applies to employers with twenty (20) or more eligible employees. The California state law is the California Continuation Benefits Replacement Act (“Cal-COBRA”). Cal-COBRA applies to California small employers with fewer than twenty (20) eligible employees. Many of the provisions of COBRA and Cal-COBRA are the same, however some differences do exist.

B. **COBRA Continuation Coverage.**

COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985 and related amendments (“COBRA”). The description of COBRA which follows is intended only to summarize the **Member’s** rights under the law. Coverage provided under this **EOC** offers no greater COBRA rights than COBRA requires and should be construed accordingly. COBRA permits eligible **Members** or eligible **Covered Dependents** to elect to continue group coverage as follows:

Employees and their Covered Dependents will not be eligible for the continuation of coverage provided by this section if the Contract Holder is exempt from the provisions of COBRA.

1. Minimum Size of Group:

The **Contract Holder** must have normally employed 20 or more employees on a typical business day during the preceding calendar year. This refers to the number of employees employed, not the number of employees covered by a health plan, and includes full-time and part-time employees.

2. Loss of coverage due to termination (other than for gross misconduct) or reduction of hours of employment:

Member may elect to continue coverage for 18 months after eligibility for coverage under this **EOC** would otherwise cease.

3. Loss of coverage due to:

- a. divorce or legal separation, or
- b. **Subscriber’s** death, or
- c. **Subscriber’s** entitlement to Medicare benefits, or
- d. cessation of **Covered Dependent** child status under the Eligibility and Enrollment section of this **EOC**.

The **Member** may elect to continue coverage for 36 months after eligibility for coverage under this **EOC** would otherwise cease.

4. Continuation coverage ends at the earliest of the following events:

- a. the last day of the 18-month period.
- b. the last day of the 36-month period.

- c. the first day on which timely payment of **Premium** is not made subject to the Premiums section of the **Group Agreement**.
 - d. the first day on which the **Contract Holder** ceases to maintain any group health plan.
 - e. the first day, after the day COBRA coverage has been elected, on which a **Member** is actually covered by any other group health plan. In the event the **Member** has a preexisting condition, and the **Member** would be denied coverage under the new plan for a preexisting condition, continuation coverage will not be terminated until the last day of the continuation period, or the date upon which the **Member's** preexisting condition becomes covered under the new plan, whichever occurs first.
 - f. the date, after COBRA coverage had been elected, when the **Member** is entitled to Medicare.
5. Extensions of Coverage Periods:
- a. The 18-month coverage period may be extended if an event which would otherwise qualify the **Member** for the 36-month coverage period occurs during the 18-month period, but in no event may coverage be longer than 36 months from the event which qualified the **Member** for continuation coverage initially.
 - b. In the event that a **Member** is determined, within the meaning of the Social Security Act, to be disabled and notifies the **Contract Holder** within 60 days of the Social Security determination and before the end of the initial 18-month period, continuation coverage for the **Member** and other qualified beneficiaries may be extended up to an additional 11 months for a total of 29 months. The **Member** must have become disabled during the first 60 days of the COBRA continuation coverage.
6. Responsibility of the **Contract Holder** to provide **Member** with notice of Continuation Rights:
- The **Contract Holder** is responsible for providing the necessary notification to **Members**, within the defined time period, as required by COBRA.
7. Responsibility to pay **Premiums** to **HMO**:
- The **Subscriber** or **Member** will only have coverage for the 60-day initial enrollment period if the **Subscriber** or **Member** pays the applicable **Premium** charges due within forty-five days of submitting the application to the **Contract Holder**.
8. **Premiums** due **HMO** for the continuation of coverage under this section shall be due in accordance with the procedures of the **Premiums** section of the **Group Agreement** and shall be calculated in accordance with applicable federal law and regulations.
9. **Members** whose coverage under COBRA is exhausted prior to 36 months from the date their COBRA continuation coverage began, may be eligible to continue coverage under Cal-COBRA for the remainder of 36 months from the date their COBRA coverage began. **Members** whose COBRA coverage terminated for reasons other than exhaustion of coverage, (for, example if **Member's** COBRA coverage was terminated for non-payment of premium) are not eligible for extension of benefits under Cal-COBRA. Notification of the opportunity to continue coverage under Cal-COBRA and instructions for application will be included in the notice to **Members** of the termination of their COBRA coverage. Additional information regarding eligibility and application for Cal-COBRA continuation coverage is provided in Section C "Cal-COBRA Continuation Coverage".

C. **Cal-COBRA Continuation Coverage**

Under Cal-COBRA, a health plan such as **HMO** that contracts with California small employers who have 2-19 eligible employees, is required to provide **Members** with the opportunity to elect Cal-COBRA

continuation coverage in certain circumstances where coverage would otherwise terminate (“qualifying events”). **HMO** will administer or contract for the administration of continuation coverage under Cal-COBRA. In order to obtain Cal-COBRA continuation coverage, **Member** and **Contract Holder** must provide **HMO** with certain notices as described below in Sections C.2 and C.3.

HMO will offer a **Member** who has exhausted continuation coverage under COBRA (if such coverage was for less than 36 months) the opportunity to continue coverage under Cal-COBRA for up to 36 months from the date the **Member’s** COBRA continuation coverage began. **HMO** will administer continuation coverage under Cal-COBRA. The notification requirements set forth in C.2 do not apply to extension of COBRA under Cal-Cobra. Additional information about the opportunity to continue coverage under Cal-COBRA, notification requirements and instructions for application will be included in the notice to **Members** of the termination of their COBRA coverage.

Throughout this section the term “qualified beneficiaries” refers to **Subscribers** and/or **Covered Dependents** who, on the day before a qualifying event, are covered under this **EOC**.

1. **Eligibility for Cal-COBRA Continuation Coverage**

- a. **Members** may be Cal-COBRA qualified beneficiaries and eligible to continue group coverage for up to 36 months if **Member’s** group coverage terminates because of one or more of the following qualifying events:
 - i. Termination of **Subscriber’s** employment (except when based on gross misconduct); or
 - ii. Reduction of **Subscriber’s** work hours below the minimum required to participate in the employer’s plan.
- b. **Covered Dependents** may be Cal-COBRA qualified beneficiaries and eligible to continue group coverage if termination occurs because of the following qualifying events:
 - i. **Subscriber’s** death (coverage for **Covered Dependents**);
 - ii. **Subscriber’s** divorce or legal separation;
 - iii. **Subscriber’s** entitlement to benefits under the Federal Medicare program;
 - iv. **Covered Dependent** child’s loss of dependent status.
- c. **Additional qualifying events.** An additional qualifying event occurs when
 - a **Member’s** coverage under this **EOC** terminates according to the Termination of Coverage section of this **EOC**;
 - the **Member** is already a qualified beneficiary and is continuing coverage under this **EOC** according to the provisions of this Cal-COBRA section;
 - and the reason for the termination is listed above under 1(b).

If a qualified beneficiary’s coverage terminates and the reason for the termination is an additional qualifying event, the qualified beneficiary is again eligible for continuation coverage. However, the **Member** must provide written notification of the additional qualifying event as described in section C.2. Examples of additional qualifying events are:

- i. **Member** is a qualified beneficiary as a **Covered Dependent** of a **Subscriber** eligible under item a. above, and later experiences an additional qualifying event as listed under item b.
 - ii. **Subscriber** is determined within the meaning of the Social Security Act, to have become disabled within the first 60 days of continuation coverage and receives such notice while covered under Cal-COBRA.
 - iii. A **Covered Dependent** child is a qualified beneficiary because of the death of the **Subscriber** and loses eligibility because of age.
- d. **COBRA Coverage Is Exhausted.** **Members** whose coverage under COBRA is exhausted prior to 36 months from the date their COBRA continuation coverage began

may be eligible to continue coverage under Cal-COBRA for up to 36 months from the date their COBRA coverage began. **Members** whose COBRA coverage terminated for reasons other than exhaustion of coverage, (if **Member's** COBRA coverage was terminated for non-payment of premium, for example) are not eligible for extension of benefits under Cal-COBRA.

- e. **Childbirth or Adoption.** Children born to or placed for adoption with a **Subscriber** who is a qualified beneficiary covered under Cal-COBRA may be enrolled for coverage within 30 days of birth or placement for adoption.

Under Cal-COBRA qualified beneficiaries receive the same benefits as other **HMO Members** in **Member's** group, but may be required to pay health plan premiums.

For qualified beneficiaries whose coverage under Cal-COBRA began prior to January 1, 2003, coverage under Cal-COBRA will not extend beyond 18 months from the date a qualified beneficiary first becomes eligible for coverage under Cal-COBRA even if the qualified beneficiary experiences a second qualifying event. Coverage for children born to or placed for adoption with a **Subscriber** who is a qualified beneficiary will end 18 months from the date coverage began for their parent. The only exception is if the **Subscriber** is determined to have become disabled under Title II or Title XVI of the Social Security Act within the first 60 days of continuation coverage, in which case the continuation coverage may be extended to 29 months.

For qualified beneficiaries whose coverage under Cal-COBRA or COBRA began on or after January 1, 2003, coverage under Cal-COBRA will not extend beyond 36 months from the date a qualified beneficiary first becomes eligible for coverage under Cal-COBRA or COBRA, even if the qualified beneficiary experiences a second qualifying event. For example, if a **Covered Dependent** became covered under Cal-COBRA due to termination of the **Subscriber's** employment, and 6 months later was divorced from the **Subscriber**, coverage would not extend beyond 36 months from the initial date of coverage under Cal-COBRA. Coverage for children born to or placed for adoption with a **Subscriber** who is a qualified beneficiary will end 36 months from the date coverage began for their parent.

2. **Cal-COBRA Notification Requirements**

If **Subscriber's** coverage and/or coverage for **Subscriber's Covered Dependents** will terminate due to a reduction of **Subscriber's** work hours or termination of **Subscriber's** employment, the **Subscriber's** employer must notify **HMO** within 30 days of the qualifying event. Notice will be sent by the employer to the **HMO's** last known address. **Subscriber** and **Covered Dependents** will be disqualified from receiving Cal-COBRA benefits if **Subscriber's** employer does not provide **HMO** with notification as required by law and summarized in the **Group Agreement**.

If a **Covered Dependent** becomes eligible for continuation coverage for any reason other than the **Subscriber's** loss of coverage due to termination of employment or reduction in hours, the **Covered Dependent** must notify **HMO** in writing of the qualifying event, within 60 days of the qualifying event. Notification should be sent to

Aetna Health of California Inc.
Plan Sponsor Services CalCOBRA
1385 East Shaw Avenue
Fresno, CA 93710.

The request must be sent via first-class mail or other reliable means of delivery. Other reliable means of delivery may include personal delivery, express mail or private courier company.

If **Covered Dependent(s)** do not notify **HMO** within sixty (60) days of the qualifying event(s), **Covered Dependent(s)** will not receive Cal-COBRA benefits.

If a **Covered Dependent** is a qualified beneficiary due to a qualifying event under C.1.a. and subsequently experiences an additional qualifying event as listed in C.1.b., the **Covered Dependent** must provide written notification of the additional qualifying event as described above in order to remain eligible for coverage under Cal-COBRA.

If the **Subscriber** who is eligible for continuation coverage as described at C.1.a, is determined to have become disabled under Title II or Title XVI of the Social Security Act at any time during the first 60 days of continuation coverage, the **HMO** must be notified within 60 days of the date of the Social Security determination letter and prior to the end of the continuation coverage period in order for the **Subscriber** to continue to be eligible for Cal-COBRA continuation coverage.

If **Subscriber** is eligible for extended continuation coverage as a result of a determination of disability, **Subscriber** must notify the **HMO** within thirty (30) days of a determination that the **Subscriber** is no longer disabled.

3. **Cal-COBRA Formal Election**

Within fourteen (14) days of receiving notification of a qualifying event, **HMO** will mail a Cal-COBRA information package to the last known address of the qualified beneficiary. The package will contain premium information, enrollment forms and the disclosures necessary to allow the qualified beneficiary(ies) to formally elect Cal-COBRA continuation benefits and will be sent to the qualified beneficiary's last known address.

To continue group coverage under Cal-COBRA **Subscriber** or the qualified beneficiary(ies) must make a formal election by submitting a written request (returning the forms in the information packet) to **HMO** at

Aetna Health of California Inc.
Plan Sponsor Services CalCOBRA
1385 East Shaw Avenue
Fresno, CA 93710.

The request must be sent via first-class or other reliable means of delivery to ensure that it is received by **HMO** within sixty (60) days of the later of the following dates:

- a. the date the qualified beneficiary receives notice of the ability to continue group coverage (the enrollment packet from the **HMO**); or
- b. the date the qualified beneficiary receives notice of the ability to continue group coverage as discussed above; or
- c. the date coverage under the employer's group health plan terminates or will terminate by reason of the qualifying event.

Other reliable means of delivery may include personal delivery, express mail or private courier company. If a formal election is not received by **HMO** within this time period, the otherwise qualified beneficiary(ies) will not receive Cal-COBRA benefits.

4. **Cal-COBRA Premium Payments**

Qualified beneficiaries who elect Cal-COBRA continuation coverage are required to pay health plan **Premiums** to **HMO**. The **Contract Holder** will no longer be making payments on the individuals' behalf. **Premium** payments must be submitted in a timely fashion to satisfy all amounts due. The exact **Premium** amount required will be included in the information package sent by **HMO** after **HMO** receives notification from **Member** that a qualifying event has occurred. The first Cal-COBRA **Premium** payment must be received by **HMO** within forty-five (45) days of the date the qualified beneficiary(ies) formally elect(s) to continue coverage under Cal-COBRA. The first **Premium** payment must satisfy any required **Premiums** and all

Premiums due. Failure to submit the correct premium amount within forty-five (45) days of formal written election will preclude the otherwise qualified beneficiary from receiving Cal-COBRA continuation coverage.

5. **Termination of Cal-COBRA Coverage**

Continuation coverage under Cal-COBRA will terminate when the first of the following occurs:

- a. for qualified beneficiaries continuing coverage under Cal-COBRA because COBRA coverage has been exhausted, at midnight on the last day of the month 36 months after the date the qualified beneficiaries' coverage under COBRA began.
- b. for qualified beneficiaries continuing coverage under Cal-COBRA according to any other qualification listed under C.1, at midnight on the last day of the month 36 months from the date coverage under this **EOC** would have terminated. The only exception is qualified beneficiaries covered by reason of a determination of disability, whose coverage began prior to January 1, 2003. For these qualified beneficiaries coverage will extend to midnight on the last day of the month 29 months from the date coverage under this **EOC** would have terminated.
- c. if the qualified beneficiary's **Premium** is not received when due, **HMO** will send a prospective notice of cancellation which will specify the date and time when coverage will terminate unless the **Premium** is received prior the date specified (the grace period). **HMO** will mail the notice to **Members** 15 days prior to the date coverage will terminate. **Member's** coverage continues during the grace period. If **Premium** is not received by the date specified in the notice, **HMO** will send **Member** a notice confirming the termination date and time and **Member** will be responsible for the **Premium** due for the coverage provided during the grace period. Upon the effective date of termination, payments, in excess of the **Premium** due for the grace period, received by **HMO** shall be refunded within 20 days to the sender.
- d. coverage terminates as set forth under the Termination of Coverage Section of this **EOC**.
- e. the **Contract Holder** ceases to provide any group benefit plan to its employees.
- f. the qualified beneficiary moves out of the **Service Area** or commits fraud or deception in the use of plan services.
- g. the group contract between **HMO** and **Contract Holder** is terminated prior to the date the qualified beneficiary's coverage would terminate. See section 6, "Cal-COBRA Continuation Coverage Upon Termination of Prior Group Health Plan" for information about electing continuation coverage under the subsequent group plan, if any.

6. **Cal-COBRA Continuation Coverage Upon Termination of Prior Group Health Plan**

If **Subscriber** and/or **Covered Dependent(s)** elect Cal-COBRA continuation coverage under **Subscriber's** current plan, and it is later replaced by another group health plan, **Subscriber** and/or **Covered Dependent(s)** may continue Cal-COBRA for the period that would have remained covered under the prior group health plan had it not terminated. To continue coverage under the new group health plan, the qualified beneficiary(ies) must comply with the requirements pertaining to enrollment in, and payment of premiums to, the new group health plan within thirty (30) days of receiving notice of termination of the prior group health plan. **Contract Holder** is responsible for notifying all qualified beneficiaries at least thirty (30) days prior to terminating a group health plan under which qualified beneficiaries are receiving Cal-COBRA continuation coverage. **Contract Holder** must further provide all qualified beneficiaries with the premium

information, enrollment forms, and disclosures necessary to allow qualified beneficiaries to continue coverage under other available group health plans.

D. Extension of Benefits While Member is Receiving Inpatient Care.

Any **Member** who is receiving inpatient care in a **Hospital** or **Skilled Nursing Facility** on the date coverage under this **EOC** terminates is covered in accordance with the **EOC** only for the specific medical condition causing that confinement or for complications arising from the condition causing that confinement, until the earlier of:

1. the date of discharge from such inpatient stay;
2. determination by the **HMO** Medical Director in consultation with the attending **Physician**, that care in the **Hospital** or **Skilled Nursing Facility** is no longer **Medically Necessary**; or
3. the date the contractual benefit limit has been reached;
4. the date the **Member** becomes covered for similar coverage from another health benefits plan;
5. 12 months of coverage under this extension of benefits provision.

The extension of benefits shall not extend the time periods during which a **Member** may enroll for continuation or conversion coverage, expand the benefits for such coverage, nor waive the requirements concerning the payment of **Premium** for such coverage.

E. Extension of Benefits Upon Total Disability.

Any **Member** who is **Totally Disabled** on the date coverage under this **EOC** terminates due to the termination of the contract between **HMO** and **Contract Holder** is covered in accordance with the **EOC**.

This extension of benefits shall only:

1. provide **Covered Benefits** that are necessary to treat medical conditions causing or directly related to the disability as determined by **HMO**; and
2. remain in effect until the earlier of the date that:
 - a. the **Member** is no longer **Totally Disabled**;
 - b. the **Member** has exhausted the **Covered Benefits** available for treatment of that condition;
 - c. the **Member** has become eligible for coverage from another health benefit plan which does not exclude coverage for the disabling condition;
 - d. after a period of 12 months in which benefits under such coverage are provided to the **Member**.

The extension of benefits shall not extend the time periods during which a **Member** may enroll for continuation or conversion coverage, expand the benefits for such coverage, nor waive the requirements concerning the payment of **Premium** for such coverage.

F. HIPAA Qualified Coverage.

Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects health insurance coverage for workers and their families when they change or lose their jobs. California law provides similar and additional protections.

If a **Member** loses coverage under this **EOC** and meets the criteria listed below, the **Member** is considered to be eligible under HIPAA (HIPAA eligible) and is entitled to purchase individual health coverage (nongroup) from *any* health plan that sells individual coverage for hospital, medical or surgical benefits. Every plan that sells individual health coverage must offer individual coverage to HIPAA eligible persons and cannot reject the HIPAA eligible person's application if the person lives or works inside the plan's service area and agrees to pay the required premiums.

A **Member** covered under this **EOC** will meet the requirements to be considered HIPAA eligible if they:

- have 18 or more months of **Creditable Coverage** without a break of 63 days or more between any of the periods of **Creditable Coverage**. (Note that coverage under this **EOC** including COBRA and Cal-COBRA are **Creditable Coverage**. See the definition of **Creditable Coverage** in the Definitions section of this **EOC** for information regarding other types of **Creditable Coverage** which could be combined with coverage under this **EOC** to meet the 18-month requirement.)
- were not terminated under this **EOC** due to nonpayment of premiums or fraud;
- are not eligible for coverage under any other group health plan, Medicare, or Medicaid;
- are not covered under any other health insurance coverage;
- have elected and exhausted the continuation coverage offered under **Continued Group Coverage (COBRA and Cal-COBRA)**.

Members may contact the Department of Managed Health Care at 1-888-HMO-2219 or visit the Department's website at www.hmohelp.ca.gov if they believe their HIPAA rights have been violated.

G. **Conversion Privilege.**

In addition to the guaranteed right to purchase individual health coverage from any health plan which sells individual health coverage **Members** under this **EOC** may enroll in the individual conversion plan offered by Aetna Health of California Inc. As required by California law, this plan provides the same benefits for the same **Premium** as the individual health plan with the most California members as determined by the department of Managed Health Care. The conversion privilege does not continue coverage under the **Group Agreement**. It permits the issuance of an individual health care coverage agreement (conversion coverage) under certain conditions.

Conversion is not initiated by **HMO**. The conversion privilege set forth in this subsection must be initiated by the eligible **Member**. The **Contract Holder** is responsible for giving notice of the conversion privilege in accordance with its normal procedures within 15 days of the termination of group coverage. In the event continuation coverage ceases pursuant to expiration of COBRA or Cal-COBRA benefits as described in the Continued Group Coverage (COBRA and Cal-COBRA) section of this **EOC**, the **Contract Holder** shall notify the **Member** at some time during the 180-day period prior to the expiration of coverage.

1. Eligibility.

In the event a **Member** ceases to be eligible for coverage under this **EOC** and has been continuously enrolled for 3 months under **HMO**, such person may, within 63 days after termination of coverage under this **EOC**, convert to individual coverage with **HMO**, effective as of the date of such termination, without evidence of insurability provided that **Member's** coverage under this **EOC** terminated for one of the following reasons:

- a. Coverage under this **EOC** was terminated, and was not replaced with continuous and similar coverage by the **Contract Holder**;
- b. The **Subscriber** ceased to meet the eligibility requirements as described in the Eligibility and Enrollment section of this **EOC**, in which case the **Subscriber** and **Subscriber's** dependents who are **Members** pursuant to this **EOC**, if any, are eligible to convert;
- c. A **Covered Dependent** ceased to meet the eligibility requirements as described in the Eligibility and Enrollment section of this **EOC** and on the Schedule of Benefits because of the **Member's** age or the death or divorce of **Subscriber**;
- d. Continuation coverage ceased under any Continuation Coverage section of this **EOC**.

Any **Member** who is eligible to convert to individual coverage, may do so in accordance with the rules and regulations governing items such as initial payment, the form of the agreement and all terms and conditions thereunder as **HMO** may have in effect at the time of **Member's** application for conversion, without furnishing evidence of insurability. The conversion coverage will provide benefits no less than what is then required by, and no benefits contrary to, any applicable law or regulation. However, the conversion coverage may not provide the same coverage, and may be less than what is provided under the **Group Agreement**. Upon request, **HMO** or the **Contract**

Holder will furnish details about conversion coverage. **Members** may call the toll-free Member Services number 1-800-756-7039, or visit the **HMO** website at Aetna.com for additional information about individual conversion plans.

2. A spouse has the right to convert upon the death of or divorce from the **Subscriber** and a **Covered Dependent** child has the right to convert upon reaching the age limit or upon death of the **Subscriber** (subject to the ability of minors to be bound by contract).
3. **Members** who are eligible for Medicare at the time their coverage under this **EOC** is terminated are not eligible for conversion.

CLAIM PROCEDURES

REVIEW OF REQUESTS FOR HEALTH CARE SERVICES

The “Claim Procedures” section explains how the **HMO** complies with Federal Department of Labor (DOL) regulations for claim determinations and appeals, (CFR 29 2560). Additional California-specific information regarding complaints and appeals is provided in the Complaints and Appeals and Independent Medical Review sections which follow. The DOL Regulations define a claim as occurring whenever a **Member** or the **Member’s** authorized representative:

- requests pre-authorization as required by the plan from **HMO**;
- requests a **Referral** as required by the plan from a **Participating Provider**;
- requests payment for services or treatment; or
- requests concurrent or retrospective utilization review.

For an **HMO Member**, most claims do not require that the **Member** submit any forms. However, if a **Member** receives a bill for **Covered Benefits**, the bill must be submitted promptly to the **HMO** for payment. Send the itemized bill for payment with the **Member’s** identification number clearly marked to the address shown on the **Member’s** ID card, within 90 days of the date the **Covered Benefit** was received, unless it is not reasonably possible to do so. To be eligible for consideration as a **Covered Benefit**, the bill for any service or supply sought or received by a **Member** must be submitted to and received by **HMO** no later than 12 months after the date the service was provided unless it can be shown that it was not reasonably possible to submit the bill and that the bill was submitted as soon as was reasonably possible.

The **HMO** will make a decision on the claim. For urgent care claims and pre-service claims, the **HMO** will send the **Member** written notification of the determination, whether adverse or not adverse. For retrospective review claims, the **HMO** will notify the member of the decision in writing no later than 30 days from the receipt of the information reasonably necessary to make the determination. For other types of claims, the **Member** may only receive notice if the **HMO** makes an adverse benefit determination.

Under Department of Labor regulations adverse benefit determinations are decisions made by the **HMO** that result in denial, reduction, or termination of a benefit or the amount paid for it. Adverse benefit determination also means a decision not to provide or to modify or delay a benefit or service. Adverse benefit determinations can be made for one or more of the following reasons:

- **Utilization Review.** **HMO** determines that the service or supply is not **Medically Necessary** or is an **Experimental or Investigational Procedure**; (Additional information about utilization review is located in the **HMO** Procedure section, item F, ‘Referrals and Pre-Authorization’.)
- **No Coverage.** **HMO** determines that a service or supply is not covered by the plan. A service or supply is not covered if it is not included in the list of **Covered Benefits**;
- A service or supply is excluded from coverage;
- An **HMO** benefit limitation has been reached; or
- **Eligibility - HMO** determines that the **Subscriber** or **Subscriber’s Covered Dependents** are not eligible to be covered by the **HMO**.

Written notice of an adverse benefit determination will be provided to the **Member** and/or **Member's Provider** within the time frames provided below. The times are measured from the **HMO's** receipt of the information reasonably necessary and requested by the **HMO** to make the determination. These time frames may be extended, if the **HMO** has requested information which has not been received or, consistent with good medical practice, has requested consultation with an expert reviewer, or requested an additional examination or additional tests. In these cases the **HMO** will notify the provider and the enrollee in writing of the reasons why a decision cannot be made within the required timeframes and the anticipated date the decision can be made. The notice of adverse benefit determination will provide the information required by California law that will assist the **Member** in making an **Appeal** of the adverse benefit determination, if the **Member** wishes to do so. Additional information regarding the **Member's** rights to Independent Medical Review for regarding denial of services determined to be **Experimental** or **Investigative** may be found in the Independent Medical Review section, Item A.

California laws and rules regulate adverse benefit determinations as **Disputed Health Care Services** or **Coverage Determinations**. Please see the Complaints and Appeals section of this **EOC** for more information about **Complaints and Appeals**.

HMO Timeframe for Decision and Notification

Type of Claim	<u>HMO Time Frame for Decision</u>	<u>HMO Time Frame for Notification of an Adverse Benefit Determination</u>
Urgent Care Claim. A claim for medical care or treatment where delay could seriously jeopardize the life or health of the Member , the ability of the Member to regain maximum function; or subject the Member to severe pain that cannot be adequately managed without the requested care or treatment.	In a timely fashion appropriate to the nature of the condition not to exceed 72 hours of HMO's receipt of the information reasonably necessary to make decision.	<ol style="list-style-type: none"> 1. If HMO is in receipt of the information reasonably necessary to make a decision when claim is submitted, as soon as possible but not later than 72 hours. 2. HMO will request any additional information necessary within 24 hours of receipt of claim. If information is received within 48 hours, within 48 hours of receipt of information. 3. If information not received within 48 hours, within 72 hours of the receipt of the initial request. If notification of decision is provided orally, written or electronic notification provided within 3 calendar days after initial oral notification.
Pre-Service Claim. A claim for a benefit that requires pre-authorization of the benefit in advance of obtaining medical care.	In a timely fashion appropriate to the nature of the condition not to exceed 5 business days of HMO's receipt of the information reasonably necessary to make decision.	Provider notified within 24 hours of decision. Member notified of decision in writing within 2 business days.
Concurrent Care Claim Extension, Reduction or Termination. A request to extend, reduce or terminate a course of treatment previously pre-authorized by HMO .	In a timely fashion appropriate to the nature of the condition not to exceed 5 business days of HMO's receipt of the information reasonably necessary to make decision.	<p>Provider notified within 24 hours of decision. Member notified in writing within 2 business days.</p> <p>In the case of decisions to terminate or reduce treatment, Member must be notified with adequate time for the Member to appeal, which time may be shorter than described above.</p>

HMO Timeframe for Decision and Notification

Type of Claim	<u>HMO Time Frame for Decision</u>	<u>HMO Time Frame for Notification of an Adverse Benefit Determination</u>
Post-Service Claim. A claim for a benefit that is not a pre-service claim.	Within 30 days of HMO's receipt of the information reasonably necessary to make decision.	Within 30 calendar days in writing

COMPLAINTS AND APPEALS

HMO has procedures for **Members** to use if they are dissatisfied with a decision that the **HMO** has made or with the operation of the **HMO**. The procedure the **Member** needs to follow will depend on the type of issue or problem the **Member** has.

- **Appeal.** An **Appeal** is a request to the **HMO** to reconsider an adverse benefit determination. The **Appeal** procedure for an adverse benefit determination has one level. An **Appeal** is a type of **Complaint**. If the **Member** is appealing a **Disputed Health Care Service**, the **Member** has the right to independent medical review in addition to the processes described in the Complaints and Appeals Section.
- **Complaint.** A **Complaint** is a written or oral expression of dissatisfaction regarding the **HMO** or the operation of the **HMO** and/or a **Provider** including quality of care concerns, and includes a grievance, dispute, request for reconsideration or **Appeal** made by an enrollee or the enrollee's representative.

A. **Complaints.**

If the **Member** is dissatisfied with the administrative services the **Member** receives from the **HMO**, or wants to complain about a **Participating Provider**, call or write Member Services within 180 calendar days of the incident. The **Member** will need to include a detailed description of the matter and include copies of any records or documents that the **Member** thinks are relevant to the matter. The **HMO** will review the information and provide the **Member** with a written response within 30 calendar days of the receipt of the **Complaint**. The response will tell the **Member** what the **Member** needs to do to seek an additional review.

B. **Appeals of Adverse Benefit Determinations.**

The **Member** will receive written notice of an adverse benefit determination (including **Coverage Decisions** and **Disputed Health Care Service** decisions) from the **HMO**. The notice will include the reason for the decision and it will explain what steps must be taken if the **Member** wishes to **Appeal**. The notice will also identify the **Member's** rights to receive additional information that may be relevant to an **Appeal**. Requests for an **Appeal** must be made in writing or by phone within 180 calendar days from the date of the notice.

A **Member** may also choose to have another person (an authorized representative) make the **Appeal** on the **Member's** behalf by providing the **HMO** with written consent. However, in case of an urgent care claim or a pre-service claim, a **Physician** may represent the **Member** in the **Appeal**.

The following chart summarizes some information about how the **Appeals** are handled for different types of claims.

HMO Timeframe for Responding to an Adverse Benefit Determination Appeal

Type of Claim	HMO Response Time from Receipt of Appeal
Urgent Care Claim. A claim for medical care	Within 72 hours.

HMO Timeframe for Responding to an Adverse Benefit Determination Appeal

Type of Claim	HMO Response Time from Receipt of Appeal
or treatment where delay could seriously jeopardize the life or health of the Member , the ability of the Member to regain maximum function; or subject the Member to severe pain that cannot be adequately managed without the requested care or treatment.	Review provided by personnel not involved in making the adverse benefit determination.
Pre-Service Claim. A claim for a benefit that requires approval of the benefit in advance of obtaining medical care.	Within 30 calendar days. Review provided by personnel not involved in making the adverse benefit determination.
Concurrent Care Claim Extension. A request to extend or a decision to reduce a previously approved course of treatment.	Treated like an urgent care claim or a pre-service claim depending on the circumstances.
Post-Service Claim. Any claim for a benefit that is not a pre-service claim.	Within 30 calendar days. Review provided by personnel not involved in making the adverse benefit determination.

C. **Exhaustion of Process.**

The foregoing procedures and process are mandatory and must be exhausted prior to: the establishing of any litigation or arbitration, or any administrative proceeding regarding either any alleged breach of the **Group Agreement** or **EOC** by **HMO**, or any matter within the scope of the **Complaints** and **Appeals** process.

D. **Record Retention.**

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

E. **Fees and Costs.**

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

F. **Review by Governmental Agencies.**

The following is a notice that the **HMO** is required to provide to **Members** that tells how to contact the **HMO** and the Department of Managed Health Care. A **Member** has the right to submit unresolved **Complaints** and **Appeals** to the California Department of Managed Health Care for review after either completing the complaints and appeals process described above or participating in the process for at least 30 days.

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your plan at 1-800-756-7039 and use the plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unsolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for

IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department has a toll-free telephone number **1-888-HMO-2219** and a TDD line **1-877-688-9891** for the hearing and speech impaired. The department's Internet Web site (<http://www.hmohelp.ca.gov>) has complaint forms, IMR application forms and instructions online."

INDEPENDENT MEDICAL REVIEW

Members have the right to an independent review of decisions by the **HMO** to deny, modify or delay coverage for health care service(s) based on Medical Necessity (**Disputed Health Care Services**). **Members** have the right to an independent medical review of decisions by the **HMO** to deny coverage for health care services which have been determined by the **HMO** to be excluded as **Experimental and Investigative**. Additional information about treatments which will not be excluded as **Experimental and Investigative** can be found under Transplant Benefits and Additional Benefits – Clinical Cancer Trials, in the Covered Benefits section of the **EOC**. Section A below describes how **Members** may request Independent Medical Review for certain Experimental and Investigative treatments related to **Life-Threatening or Seriously Debilitating Illnesses**. The Department of Managed Health Care will manage the independent medical review process, which is available to **Members** when they meet the criteria developed by the Department of Managed Health Care. **Members** are not required to pay any application or processing fees to request or receive independent medical review. Independent medical review is available in addition to **HMO Complaint** and **Appeal** procedures and any other remedies available to the **Member** by law. **Members** should be aware that the decision not to participate in the independent medical review process may cause the **Member** to forfeit any statutory right to pursue legal action against the **HMO** regarding a **Disputed Health Care Service**.

A. Independent Medical Review Procedure for Experimental and Investigative Treatment

Members have the right to request an independent medical review when coverage is denied as an **Experimental or Investigational Procedure** and the following conditions are met:

1. The **Member** has a **Life-Threatening or Seriously Debilitating Illness**; and
2. The **Member's Physician** certifies that the **Member** has a condition, described in 1 above, for which
 - a) standard therapies have not been effective in improving the condition of the **Member**, or
 - b) standard therapies would not be medically appropriate, or
 - c) there is no more beneficial standard therapy covered by the plan than the therapy proposed by the **Physician**, and
- 3) the **Member's Participating Physician** has certified in writing that the proposed procedure, device, drug or other therapy is more likely to be more beneficial to the **Member** than any available standard therapies, or
- 4) the **Member**, or the **Member's Physician** (who is a licensed, board-certified or board-eligible **Physician**, qualified to practice in the area of practice appropriate to treat the **Member's** condition) has provided to **HMO** a written statement which certifies that, based on two documents from **Medical and Scientific Evidence** the requested, drug, device, procedure or therapy is likely to be more beneficial to the **Member** than any available standard therapy. The **Physician** or the **Member** must identify the documents relied upon as **Medical and Scientific Evidence** as part of the written certification.

When coverage for a requested service is denied as **Experimental and Investigative**, the **HMO** must notify the **Member** in writing, within five business days of the date of the decision to deny coverage, of the **Member's** right to request independent medical review. Included in the notice will be the forms and instructions necessary to apply to the Department of Managed Health Care for independent medical review

of the **HMO's** decision. The **Member** will need to demonstrate to the Department of Managed Health Care that they meet criteria (1), (2) and (3), or criteria (1), (2) and (4).

The independent medical review will be a review of the specific medical and scientific reasons cited by the **HMO** for the denial of coverage. The review will be done at no cost to the **Member**. The Department of Managed Health Care will evaluate the **Member's** request and decide whether the **Complaint** qualifies for independent medical review. The Department of Managed Health Care will notify the **Member** and the **HMO** of its decision. Within three business days of notification from the Department of Managed Health Care that the **Member's** request for independent medical review has been approved, the **HMO** must provide the independent entity performing the review with the medical records relevant to the **Member's** condition, a copy of the relevant documents used by the **HMO** in determining whether the proposed treatment is covered, and any other information submitted to the **HMO** by the **Member** or the **Member's Physician** in support of the request for coverage.

If the **Member's Provider** determines that the effectiveness of either the proposed treatment or any alternative treatment covered under this **EOC** would be materially reduced if not provided at the earliest possible date, the review shall be done within 7 business days of the date of the request and the **HMO** shall submit the above referenced documents within 24 hours of the Department of Managed Health Care's notification to the **HMO** that the **Member's Complaint** qualifies for expedited independent medical review.

B. Independent Medical Review Procedure for Disputed Health Care Services.

As part of the **Complaint** and **Appeal** process, **Members** have the right to an independent medical review of their **Appeal**, when they believe that health care services have been improperly denied, modified, or delayed because they are not **Medically Necessary** (a **Disputed Health Care Service**), and the conditions listed below are met.

1. The **Member** has filed an **Appeal** regarding a **Disputed Health Care Service**.
2. The **Member** has participated in the **HMO Complaint** and **Appeal** process for 30 days or the **HMO** has responded to the **Member's Appeal** by upholding the **HMO's** denial of the **Disputed Health Care Service**. In cases involving an expedited complaint or appeal the **Member** is not required to participate in the **HMO Complaint** and **Appeal** process for more than three days.
3. Either, the **Member's Provider** (who may be a non-participating **Provider**, subject to the conditions noted below) must have recommended the health care service as medically necessary; or the **Member** received **Urgent Care** or **Emergency Services** that a **Provider** deemed medically necessary.
4. Or, the **Member** has been seen by a **Participating Provider** for the diagnosis or treatment of the medical condition for which the **Member** seeks independent review. Upon request by a **Member**, **HMO** will expedite access to a **Participating Provider**. Note that the **Member** may request independent medical review for the **Disputed Health Care Service** whether or not the **Participating Provider** recommends the service.

Members may request an independent medical review for services recommended or performed by a Non-Participating Provider, but the HMO has no liability to pay for the services of a Non-Participating Provider unless the Member has been referred to the Non-Participating Provider according to the requirements set forth in this EOC.

When the **HMO** receives notice from the Department of Managed Health Care approving the **Member's** request for an independent medical review, the **HMO** will submit the documents required by Health and Safety section 1374.30(n) within 3 business days.

HMO will concurrently provide a copy of these documents to the **Member** and the **Member's Provider**.

In the event of the imminent and serious threat to the health of the **Member**, the **HMO** will deliver the required documents to the Independent Medical Review Organization within 24 hours of receipt of notification of the Department of Managed Health Care's approval of the **Member's** request.

C. **Department of Managed Health Care and Independent Medical Review.**

If the **Member** wishes to pursue independent medical review the **Member** should complete the form which the **Member** will have received from the **HMO** and send it (in the envelope provided with the form and instructions) to the Department of Managed Health Care. The Department will review the **Member's** request and determine whether the **Member** meets the criteria for independent medical review and therefore, is eligible for independent medical review. If the Department of Managed Health Care approves the **Member's** request, the **Member's Appeal** will be submitted to the Independent Medical Review Organization for review by a medical specialist, or a panel of medical specialists. The designated specialist or panel of specialists will make an independent determination of whether or not the care which is the subject of the **Appeal** is medically necessary. The **Member** will receive a copy of the independent medical review assessment of the **Appeal**. If the outcome of the independent medical review is that the care requested is medically necessary or does not qualify as **Experimental and Investigative**, the **HMO** will cover the provision of the health care services which were the subject of the **Appeal**.

For non-urgent cases, the independent medical review organization must provide its determination within 30 days of receiving the **Member's** application and supporting documents. For cases which qualify for expedited review, the Independent Medical Review Organization must provide its determination within 3 business days.

Upon notification of an independent medical review decision that the health care services under review are medically necessary, **HMO** will promptly take the actions necessary to comply with the decision.

BINDING ARBITRATION

Binding arbitration is the final process for resolving any disputes between Interested Parties arising from or related to **HMO** coverage, whether stated in tort, contract or otherwise. This includes (but is not limited to) disputes involving alleged professional liability or medical malpractice (that is, whether any medical services were unnecessary or unauthorized or were improperly, negligently or incompetently rendered). Interested Parties are **Contract Holder, Members**, the heirs-at-law or personal representative(s) of a **Member**, a **Participating Provider** and **HMO**, including any affiliates agents, employees or subcontractors of an Interested Party. This agreement to arbitrate shall be specifically enforced even if a party to the arbitration is also a party to another proceeding with a third party arising out of the same matter. All Interested Parties are giving up their constitutional right to have their dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration. This means that Interested Parties will not be able to try their case in court.

Unless otherwise agreed by the parties to the arbitration, all disputes shall be submitted to neutral arbitration within the **HMO** Service Area to the American Arbitration Association (AAA) or such other neutral dispute resolution organization as mutually agreed by the parties. The AAA can be reached by calling (213) 383-6516 (Los Angeles), (415) 981-3901 (San Francisco), or (619) 239-3051 (San Diego). If the AAA declines the case or the parties do not agree on an alternative organization, then a neutral arbitrator shall be appointed upon petition to the court under California Code of Civil Procedure Section 1281.6. The arbitration shall occur in the **Member's** choice of Los Angeles, San Francisco, or San Diego unless otherwise agreed or determined by the arbitrator.

If AAA is chosen as the neutral arbitrator, **HMO** will follow AAA rules regarding payment of fees. In cases of extreme hardship to a **Member**, the **Member** may request at any time that the arbitrator or dispute resolution organization may allocate all or a portion of the **Member's** share of the arbitrator's fees and expenses to **HMO**. For more information regarding this arbitration process, please call the **HMO** phone number located on the **Member's** ID card.

The arbitrator will establish the procedures which will govern the arbitration, including procedures concerning discovery. The arbitrator is bound by applicable state and federal law and regulations and shall issue a written opinion setting forth findings of fact, conclusions of law and the basis of the decision. The arbitrator is authorized to award equitable as well as legal relief to the extent permitted by law. The parties expressly agree and covenant to be bound by the decision of the arbitrator as a final determination of the matter in dispute, subject only to such grounds as are available to challenge an arbitration decision under California law. This arbitration provision is subject to enforcement and interpretation under the Federal Arbitration Act.

In addition, the enforceability of this arbitration provision is determined by various state laws, including California Health & Safety Code Section 1363.1. In certain situations Aetna will not seek to enforce the arbitration provision. Prior to August 1, 1999, Aetna's **HMO** plans did not require arbitration and **HMO** enrollment forms in use during that time period did not contain information regarding binding arbitration. If you enrolled in an Aetna commercial **HMO** Plan prior to August 1, 1999, the arbitration clause in your **EOC** may not be enforceable, and therefore, Aetna will not seek to enforce that provision. Further, some Aetna members have been enrolled in Aetna's commercial **HMO** Plan through an Integrated Multiple Option ("IMO") arrangement. Aetna's IMO enrollment form (form No. 67269) did not contain information regarding binding arbitration. Therefore, if you enrolled in the Aetna **HMO** Plan by signing that IMO enrollment form, the arbitration clause in your **EOC** may not be enforceable, and Aetna will not seek to enforce that provision.

REQUEST FOR BINDING ARBITRATION

If the **Member** does not agree with **HMO's** final determination, the **Member** may, within 60 days of **HMO's** written notice of its final determination and/or any external independent review decisions, initiate binding arbitration as described in the following section, or initiate litigation, to the extent provided for under Federal law pursuant to the Employee Retirement Income Security Act.

LIMITATIONS ON REMEDIES

A. No Jury Trial

In any dispute arising from or related to **HMO** coverage, there shall be no right to a jury trial. The right to trial by a jury is expressly waived.

B. Medical Malpractice Claims

Any claim alleging wrongful acts or omissions of **Participating Providers** shall not include **HMO** and shall include only **Participating Providers** subject to the allegation. **Members** waive their right to bring any such claim against **HMO** as a party in any such claim.

C. Punitive Damages

Any award of punitive damages must be authorized by and recoverable under all applicable law, be based upon clear and convincing evidence of outrageous conduct by **HMO**, and bear reasonable relationship to actual recoverable damages. No punitive damages related to the denial or the reduction of benefits or payment shall be recoverable where the **Member** has not pursued external independent medical review where available, the External Reviewer has confirmed the **HMO's** decision, or the **HMO** has abided by the decision of the External Reviewer.

D. Class Actions

No **Member** may participate in a representative capacity or as a member of any class of claimants in any proceeding arising from or related to **HMO** coverage. Claims brought by any **Member** (including his/her **Covered Dependents**) may not be joined or consolidated with claims brought by any other **Member(s)** unless otherwise agreed to in writing by **HMO**. Any right to participate in a class or in a representative capacity, or to join or consolidate claims with other parties, is expressly waived.

COORDINATION OF BENEFITS

Definitions. When used in this provision, the following words and phrases have the following meaning:

Allowable Expense. A health care service or expense, including coinsurance and **Copayments**, that is covered at least in part by any of the **Plans** covering the **Member**. When a **Plan** provides benefits in the form of services the reasonable cash value of each service will be considered an **Allowable Expense** and a benefit paid. An expense or service that is not covered by any of the **Plans** is not an **Allowable Expense**. The following are examples of expenses and services that are not **Allowable Expenses**:

1. If a **Member** is confined in a private **Hospital** room, the difference between the cost of a semi-private room in the **Hospital** and the private room (unless the **Member's** stay in the private **Hospital** room is **Medically Necessary** in terms of generally accepted medical practice, or one of the **Plans** routinely provides coverage of **Hospital** private rooms) is not an **Allowable Expense**.
2. If a **Member** is covered by 2 or more **Plans** that compute their benefit payments on the basis of **Reasonable Charge**, any amount in excess of the highest of the **Reasonable Charges** for a specific benefit is not an **Allowable Expense**.
3. If a **Member** is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable Expense**.
4. The amount a benefit is reduced by the **Primary Plan** because a **Member** does not comply with the **Plan** provisions. Examples of these provisions are second surgical opinions, pre-authorization of admissions, and preferred provider arrangements.

If a **Member** is covered by 1 **Plan** that calculates its benefits or services on the basis of **Reasonable Charges** and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary Plan's** payment arrangements shall be the **Allowable Expense** for all the **Plans**.

Claim Determination Period. The calendar year.

Closed Panel Plan(s). A **Plan** that provides health benefits to **Members** primarily in the form of services through a panel of **Providers** that have contracted with or are employed by the **Plan**, and that limits or excludes benefits for services provided by other **Providers**, except in cases of **Emergency Services** or **Referral** by a panel **Provider**.

Coordination of Benefits (COB). A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by 2 or more plans. It avoids claims payment delays by establishing an order in which plans pay their claims and providing the authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first.

Custodial Parent. A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Medicare. The health insurance provided by Title XVIII of the Social Security Act, as amended. It includes **HMO** or similar coverage that is an authorized alternative to Parts A and B of **Medicare**.

Plan(s). Any **Plan** providing benefits or services by reason of medical or dental care or treatment, which benefits or services are provided by one of the following:

1. Group, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
2. Other prepaid coverage under service plan contracts, or under group or individual practice;
3. Uninsured arrangements of group or group-type coverage;

4. Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans;
5. Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group.

If the contract includes both medical and dental coverage those coverages will be considered separate **Plans**. The Medical/Pharmacy coverage will be coordinated with other Medical/Pharmacy **Plans**. In turn, the dental coverage will be coordinated with other dental **Plans**.

Plan Expenses. Any necessary and reasonable health expenses, part or all of which are covered under this **Plan**.

Primary Plan/Secondary Plan. The order of benefit determination rules state whether coverage under this **EOC** is a **Primary Plan** or **Secondary Plan** as to another **Plan** covering the **Member**.

When coverage under this **EOC** is a **Primary Plan**, its benefits are determined before those of the other **Plan** and without considering the other **Plan's** benefits.

When coverage under this **EOC** is a **Secondary Plan**, its benefits are determined after those of the other **Plan** and may be reduced because of the other **Plan's** benefits.

When there are more than 2 **Plans** covering the person, coverage under this **EOC** may be a **Primary Plan** as to 1 or more other **Plans**, and may be a **Secondary Plan** as to a different **Plan(s)**.

This **Coordination of Benefits (COB)** provision applies to this **EOC** when a **Subscriber** or the **Covered Dependent** has medical and/or dental coverage under more than 1 **Plan**.

The Order of Benefit Determination Rules below determines which **Plan** will pay as the **Primary Plan**. The **Primary Plan** pays first without regard to the possibility that another **Plan** may cover some expenses. A **Secondary Plan** pays after the **Primary Plan** and may reduce the benefits it pays so that payments from all group **Plans** do not exceed 100% of the total **Allowable Expense**.

Order of Benefit Determination.

When 2 or more **Plans** pay benefits, the rules for determining the order of payment are as follows:

- A. The **Primary Plan** pays or provides its benefits as if the **Secondary Plan(s)** did not exist.
- B. A **Plan** that does not contain a **COB** provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the **Plan** provided by the **Contract Holder**. Examples of this type of exception are major medical coverages that are superimposed over base plan providing **Hospital** and surgical benefits, and insurance type coverages that are written in connection with a **Closed Panel Plan** to provide out-of-network benefits.
- C. A **Plan** may consider the benefits paid or provided by another **Plan** in determining its benefits only when it is secondary to that other **Plan**.
- D. The first of the following rules that describes which **Plan** pays its benefits before another **Plan** is the rule which will govern:
 1. **Non-Dependent or Dependent.** The **Plan** that covers the person other than as a dependent, for example as an employee, **Subscriber** or retiree is primary and the **Plan** that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to

the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the 2 **Plans** is reversed so that the **Plan** covering the person as an employee, **Subscriber** or retiree is secondary and the other **Plan** is primary.

2. **Dependent Child Covered Under More Than One Plan.** The order of benefits when a child is covered by more than one **Plan** is:

- a. The **Primary Plan** is the **Plan** of the parent whose birthday is earlier in the year if:
- The parents are married;
 - The parents are not separated (whether or not they ever have been married); or
 - A court decree awards joint custody without specifying that 1 party has the responsibility to provide health care coverage.

If both parents have the same birthday, the **Plan** that covered either of the parents longer is primary.

- b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to **Claim Determination Periods** or **Plan** years commencing after the **Plan** is given notice of the court decree.

- c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

- The **Plan** of the **Custodial Parent**;
- The **Plan** of the spouse of the **Custodial Parent**;
- The **Plan** of the non-custodial parent; and then
- The **Plan** of the spouse of the non-custodial parent.

3. **Active or Inactive Employee.** The **Plan** that covers a person as an employee who is neither laid-off nor retired, is the **Primary Plan**. That **Plan** is also the **Primary Plan** if a person is a dependent of a person covered as a retiree and an employee, who is neither laid-off nor retired. This means that a **Plan** that covers a **Member** as an employee, or the **Covered Dependent** of the **Member** is the **Primary Plan** in relation to a **Plan** that covers the **Member** as a laid-off or retired employee or dependent of the **Member**. If the other **Plan** does not have this rule, and if, as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. Coverage provided to an individual as a retired worker and as a dependent of an actively working spouse will be determined under the above rule labeled D(1).

4. **Continuation Coverage.** If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another **Plan**, the **Plan** covering the person as an employee, **Member**, **Subscriber** or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other **Plan** does not have this rule, and if, as a result, the **Plans** do not agree on the order of benefits, this rule is ignored.

5. **Longer or Shorter Length of Coverage.** The **Plan** that covered the person as an employee, **Member** or **Subscriber** longer is primary.

6. **If the preceding rules do not determine the Primary Plan,** the **Allowable Expenses** shall be shared equally between the **Plans** meeting the definition of **Plan** under this section. In addition, this **Plan** will not pay more than it would have paid had it been primary.

Effect On Benefits of This EOC.

- A. When this **Plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a **Claim Determination Period** are not more than 100% of total **Allowable Expenses**. The difference between the benefit payments that this **Plan** would have paid had it been the **Primary Plan**, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the **Member** and used by this **Plan** to pay any **Allowable Expenses** not otherwise paid during the claim determination period. As each claim is submitted, this **Plan** will:
1. Determine its obligation to pay or provide benefits under its contract;
 2. Determine whether a benefit reserve has been recorded for the **Member**; and
 3. Determine whether there are any unpaid **Allowable Expenses** during that **Claims Determination Period**.
- B. If a **Member** is enrolled in 2 or more **Closed Panel Plans** and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by 1 **Closed Panel Plan**, **COB** shall not apply between that **Plan** and other **Closed Panel Plans**.

Multiple Coverage Under This Plan.

If a **Member** is covered under this **Plan** both as a **Subscriber** and a **Covered Dependent** or as a **Covered Dependent** of 2 **Subscribers**, the following will also apply:

- The **Member's** coverage in each capacity under this **Plan** will be set up as a separate "**Plan**".
- The order in which various **Plans** will pay benefits will apply to the "**Plans**" set up above and to all other **Plans**.
- This provision will not apply more than once to figure the total benefits payable to the person for each claim under this **Plan**.

Right to Receive and Release Needed Information.

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits under this **Plan** and other **Plans**. Any person claiming benefits under this **Plan** shall furnish such information as may be necessary to implement this provision. **HMO** has the right to release or obtain any information it considers necessary in order to administer this provision.

Facility of Payment.

Any payment made under another **Plan** may include an amount which should have been paid under coverage under this **EOC**. If so, **HMO** may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under this **EOC**. **HMO** will not have to pay that amount again. The term "payment made" includes reasonable cash value of the benefits provided in the form of services.

Right of Recovery.

If the amount of the payments made by **HMO** is more than it should have paid under this **COB** provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the **Member**. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

EFFECT OF MEDICARE ON COVERAGE UNDER THIS EOC

When the **Member** is covered under **Medicare**, benefits under this **EOC** are reduced by any benefits the **Member** is entitled to under **Medicare** in accordance with **Medicare's** rules regarding whether **Medicare** is the primary or secondary payer.

RIGHT OF REIMBURSEMENT RECOVERY

As used herein, the term “Third Party” means any party that is, or may be, or is claimed to be responsible for injuries or illness to a **Member**. Such injuries or illness are referred to as “Third Party injuries.” “Responsible Party” includes any parties actually, possibly or potentially responsible for payment of expenses associated with the care or treatment of Third Party injuries.

If this Plan pays benefits under this **EOC** to a **Member** for expenses incurred due to Third Party injuries, then the **HMO** retains the right to repayment of the full cost of all benefits provided by this Plan on behalf of the **Member** that are associated with the Third Party injuries. The **HMO**’s rights of recovery apply to any recoveries made by or on behalf of the **Member** from any sources, including but not limited to: payments made by a Third Party or any insurance company on behalf of the Third Party; any payments or awards under an uninsured or underinsured motorist coverage policy; any Workers’ Compensation or disability award or settlement; medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; and any other payments from a source intended to compensate a **Member** for Third Party injuries. In some cases, **Participating Providers** may also assert the **HMO**’s lien. Some **Providers** also have lien rights that are independent of the **HMO**’s rights stated in this section. For health care benefits for which a **Participating Provider** has been paid capitation, the lien will be limited to 80% of the usual and customary charge for the same service charged in the geographic region on a fee for service basis.

By accepting benefits under this Plan, the **Member** specifically acknowledges the **HMO**’s right of reimbursement. This right of reimbursement attaches when this Plan has paid health care benefits for expenses incurred due to Third Party injuries and the **Member** or the **Member**’s representative has recovered any amounts from any sources, including but not limited to: payments made by a Third Party or any insurance company on behalf of the Third Party; any payments or awards under an uninsured or underinsured motorist coverage policy; any Workers’ Compensation or disability award or settlement; medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; and any other payments from a source intended to compensate a **Member** for Third Party injuries. By providing any benefit under the **EOC**, the **HMO** is granted an assignment of the proceeds of any settlement, judgment or other payment received by the **Member** to the extent of the full cost of all benefits provided by this Plan. By accepting benefits under this Plan, the **Member** and the **Member**’s representatives further agree to:

- A. Notify the **HMO** promptly and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to Third Party injuries sustained by the **Member**.
- B. Cooperate with the **HMO** and provide the **HMO** with all requested information necessary to secure the **HMO**’s right of reimbursement under this **EOC**.
- C. Grant the **HMO** a lien on or reimburse the **HMO** from any recovery, settlement, judgment or other source of compensation obtained by **Member** or **Member**’s representative. The amount of the lien or reimbursement owed will be based on the reasonable cost of benefits associated with Third Party injuries paid by this Plan. The amount of the lien or reimbursement owed will be reduced by the same percentage of comparative fault, if any, by which the **Member**’s recovery was reduced by a judge, jury or arbitrator. The amount of the lien or reimbursement owed will also be reduced by a pro rata share of the **Member**’s reasonable attorney’s fees and costs. The amount of the lien or reimbursement owed will not exceed one-third of the recovery, settlement, judgment or other source of compensation if the **Member** engaged an attorney or one-half of the recovery, settlement, judgment or other source of compensation if the **Member** did not engage an attorney. These limitations do not apply to a lien made against a workers’ compensation claim.
- D. Do nothing to prejudice the **HMO**’s rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid by this Plan.

- E. Serve as a constructive trustee for the benefit of this Plan over any settlement or recovery funds received as a result of Third Party injuries.

In the event the **Member** or the **Member's** representative fails to reimburse the **HMO** (according to the terms of this provision), the **Member** shall be responsible for all benefits paid by this Plan in addition to costs and attorney's fees incurred by the **HMO** in obtaining repayment.

RECOVERY RIGHTS RELATED TO WORKERS' COMPENSATION

If benefits are paid by the **HMO** for illness or injuries to a **Member** and the **HMO** determines the **Member** received Workers' Compensation benefits for the same incident that resulted in the illness or injuries, the **HMO** has the right to recover as described under the Right of Reimbursement Recovery provision. The **HMO** will pay benefits in the case of valid disputes as to the work-relatedness of the illness or injury on the condition that the **Member** cooperates with the **HMO**. The **Member** shall provide information that will allow the **HMO** to pursue potential recovery rights if the injury is ultimately deemed to be work-related. "Workers' Compensation benefits" includes benefits paid in connection with a Workers' Compensation claim, whether paid by an employer directly, a workers' compensation insurance carrier, or any fund designed to provide compensation for workers' compensation claims. The **HMO** will exercise its Recovery Rights against the **Member**.

The Recovery Rights will be applied even though:

- a) The Workers' Compensation benefits are in dispute or are paid by means of settlement or compromise;
- b) The amount of Workers' Compensation benefits due to medical or health care is not agreed upon or defined by the **Member** or the Workers' Compensation carrier.

By accepting benefits under this Plan, the **Member** or the **Member's** representatives agree to notify the **HMO** of any Workers' Compensation claim made, and to reimburse the **HMO** as described above.

RESPONSIBILITY OF MEMBERS

- A. **Members** or applicants shall complete and submit to **HMO** such application or other forms or statements as **HMO** may reasonably request. **Members** represent that all information contained in such applications, forms and statements submitted to **HMO** incident to enrollment under this **EOC** or the administration herein shall be true, correct, and complete to the best of the **Member's** knowledge and belief.
- B. The **Member** shall notify **HMO** immediately of any change of address for the **Member** or any of the **Member's Covered Dependents**, unless a different notification process is agreed to between **HMO** and **Contract Holder**.
- C. The **Member** understands that **HMO** is acting in reliance upon all information provided to it by the **Member** at time of enrollment and afterwards and represents that information so provided is true and accurate.
- D. By electing coverage pursuant to this **EOC**, or accepting benefits hereunder, all **Members** who are legally capable of contracting, and the legal representatives of all **Members** who are incapable of contracting, at time of enrollment and afterwards, represent that all information so provided is true and accurate and agree to all terms, conditions and provisions hereof.
- E. **Members** are subject to and shall abide by the rules and regulations of each **Provider** from which benefits are provided.

GENERAL PROVISIONS

- A. **Identification Card.** The identification card issued by **HMO** to **Members** pursuant to this **EOC** is for identification purposes only. Possession of an **HMO** identification card confers no right to services or

benefits under this **EOC**, and misuse of such identification card may be grounds for termination of **Member's** coverage pursuant to the Termination of Coverage section of this **EOC**. If the **Member** who misuses the card is the **Subscriber**, coverage may be terminated for the **Subscriber** as well as any of the **Covered Dependents**. To be eligible for services or benefits under this **EOC**, the holder of the card must be a **Member** on whose behalf all applicable **Premium** charges under this **EOC** have been paid. Any person receiving services or benefits which such person is not entitled to receive pursuant to the provisions of this **EOC** shall be charged for such services or benefits at billed charges.

If any **Member** permits the use of the **Member's HMO** identification card by any other person, such card may be retained by **HMO**, and all rights of such **Member** and their **Covered Dependents**, if any, pursuant to this **EOC** shall be terminated immediately, subject to the **Complaint** procedure set forth in the Complaints and Appeals/Independent Medical Review sections of this **EOC**.

- B. **Reports and Records.** **HMO** is entitled to receive from any **Provider** of services to **Members**, information reasonably necessary to administer this **EOC** subject to all applicable confidentiality requirements as defined in the General Provisions section of this **EOC**. By accepting coverage under this **EOC**, the **Subscriber**, for himself or herself, and for all **Covered Dependents** covered hereunder, authorizes each and every **Provider** who renders services to a **Member** hereunder to:
1. disclose all facts pertaining to the care, treatment and physical condition of the **Member** to **HMO**, or a medical, dental, or mental health professional that **HMO** may engage to assist it in reviewing a treatment or claim;
 2. render reports pertaining to the care, treatment and physical condition of the **Member** to **HMO**, or a medical, dental, or mental health professional that **HMO** may engage to assist it in reviewing a treatment or claim; and
 3. permit copying of the **Member's** records by **HMO**.
- C. **Refusal of Treatment.** A **Member** may, for personal reasons, refuse to accept procedures, medicines, or courses of treatment recommended by a **Participating Provider**. If the **Participating Provider** (after a second **Participating Provider's** opinion, if requested by **Member**) believes that no professionally acceptable alternative exists, and if after being so advised, **Member** still refuses to follow the recommended treatment or procedure, neither the **Participating Provider**, nor **HMO**, will have further responsibility to provide any of the benefits available under this **EOC** for treatment of such condition or its consequences or related conditions. **HMO** will provide written notice to **Member** of a decision not to provide further benefits for a particular condition. This decision is subject to the **Complaint** procedure set forth in the Complaints and Appeals/Independent Medical Review sections of this **EOC**. Coverage for treatment of the condition involved will be resumed in the event **Member** agrees to follow the recommended treatment or procedure.
- D. **Assignment of Benefits.** All rights of the **Member** to receive benefits hereunder are personal to the **Member** and may not be assigned.
- E. **Legal Action.** No claim in law or in equity may be maintained against **HMO** for any expense or bill prior to the expiration of 60 days after written submission of claim has been furnished in accordance with requirements set forth in this **Group Agreement**. No action shall be brought after the expiration of 3 years after the time written submission of claim is required to be furnished.
- F. **Independent Contractor Relationship.**
1. **Participating Providers**, non-participating **Providers**, institutions, facilities or agencies are neither agents nor employees of **HMO**. Neither **HMO** nor any **Member** of **HMO** is an agent or employee of any **Participating Provider**, non-participating **Provider**, institution, facility or agency. **Members** shall not include **HMO** as a party in any legal proceeding alleging medical malpractice.

2. Neither the **Contract Holder** nor a **Member** is the agent or representative of **HMO**, its agents or employees, or an agent or representative of any **Participating Provider** or other person or organization with which **HMO** has made or hereafter shall make arrangements for services under this **EOC**.
3. **Participating Physicians** maintain the physician-patient relationship with **Members** and are solely responsible to **Member** for all **Medical Services** which are rendered by **Participating Physicians**.
4. **HMO** cannot guarantee the continued participation of any **Provider** or facility with **HMO**.

For purposes of this section, Provider Group means a medical group, independent practice association, or other similar organization.

- a. In the event the **HMO** terminates its contract with a **PCP**, or when an individual provider leaves a contracted provider group, **HMO** shall provide notification to **Members** of **PCP** termination in the following manner:
 - i. At least 60 days prior to the termination date the **HMO** will send written notification to **Members** who are currently enrolled in the **PCP's** office; or are receiving an **Active Course of Treatment** from other terminating **Providers** affiliated with the **PCP**.
 - ii. **Members** must notify the **HMO** of their new choice of **PCP** prior to the date of the **PCP's** termination, or **HMO** will assign a new **PCP** to the **Member**.
- b. In the event the **HMO** terminates its contract with a Provider Group or **Hospital**, or a Provider Group or **Hospital** terminates its contract with **HMO**, **HMO** shall provide notification to **Members** in the following manner:
 - i. At least 60 days prior to the anticipated termination date the **HMO** will send written notification to **Members** whose **PCP** is part of the terminating Medical Group or who live within a 15 mile radius of the terminating **Hospital**.
 - ii. **Members** will be assigned to a new **PCP** and information regarding the new **PCP** assignment will be included in the notice.
 - iii. If the Provider, Provider Group or **Hospital** termination does not occur, **Members** will be notified and given the opportunity to return to their previous **PCP**.

Members undergoing an **Active Course of Treatment** may refer to the **HMO** Procedure section, "Requesting Continuity of Care", for information about how to continue treatment with a terminated **Provider** for a limited time.

5. **Restriction on Choice of Providers:** Unless otherwise approved by **HMO**, **Members** must utilize **Participating Providers** and facilities that have contracted with **HMO** to provide services. When **Member** needs a **Specialist**, **Member's PCP** will provide **Member** with an authorized **Referral** to a **Participating Provider** within the **PCP's** associated medical group or IPA, unless it is **Medically Necessary** to refer **Member** to a **Specialist** outside of the **PCP's** associated medical group or IPA or to a non-**Participating Provider**. **Referral** to a non-participating **Provider** must be pre-authorized by **HMO**. For certain services, **Member's PCP** must also obtain prior authorization from **HMO**.
- G. **Medical Malpractice Claims.** In no event shall **HMO** be liable for the negligence, wrongful acts or omissions of **Participating Providers**. ANY CLAIM ALLEGING SUCH NEGLIGENCE, WRONGFUL ACTS OR OMISSIONS (INCLUDING BUT NOT LIMITED TO MEDICAL MALPRACTICE) SHALL NOT INCLUDE **HMO** AND SHALL INCLUDE ONLY THE **PROVIDERS** SUBJECT TO THE ALLEGATION. BY ENROLLING IN THIS PLAN, **MEMBERS** WAIVE THEIR RIGHT TO BRING ANY CLAIM AGAINST **HMO**, OR TO JOIN **HMO** AS A PARTY IN ANY SUCH CLAIM,

REGARDING SUCH DISPUTES. **Members** understand and acknowledge that **HMO** and **Participating Providers** are independent contractors in relation to one another and no joint venture, partnership, employment, agency or other relationship is created by this **Evidence of Coverage** or the **Group Agreement**.

- H. **Inability to Provide Service.** If due to circumstances not within the reasonable control of **HMO**, including but not limited to, major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of the **Participating Provider** Network, the provision of medical or **Hospital** benefits or other services provided under this **EOC** is delayed or rendered impractical, **HMO** will make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event. Under these circumstances, medical groups and hospitals will do their best to provide services, but if **Participating Providers** are not available, **Members** should go to the nearest **Provider** or **Hospital** for emergency services. The **HMO** will provide appropriate reimbursement later.
- I. **Confidentiality.** Information contained in the medical records of **Members** and information received from any **Provider** incident to the provider-patient relationship shall be kept confidential in accordance with applicable law. Information may be used or disclosed by **HMO** when necessary for a **Member's** care or treatment, the operation of **HMO** and administration of this **EOC**, or other activities, as permitted by applicable law. **Members** can obtain a copy of **HMO's** Notice of Information Practices by calling the Member Services toll-free telephone number 1-800-756-7039.
- J. **Limitation on Services.** Except in cases of **Emergency Services** or **Urgent Care**, as provided under this **EOC**, services are available only from **Participating Providers** and **HMO** shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a **Member** from any **Physician, Hospital, Skilled Nursing Facility**, home health care agency, or other person, entity, institution or organization unless prior arrangements are made by **HMO**.
- K. **Incontestability.** In the absence of fraud, all statements made by a **Member** shall be considered representations and not warranties, and no statement shall be the basis for voiding coverage or denying a claim after the **Group Agreement** has been in force for 2 years from its effective date, unless the statement was material to the risk and was contained in a written application.
- L. This **EOC** applies to coverage only, and does not restrict a **Member's** ability to receive health care services that are not, or might not be, **Covered Benefits**.
- M. **Contract Holder** hereby makes **HMO** coverage available to persons who are eligible under the Eligibility and Enrollment section of this **EOC**. However, this **EOC** shall be subject to amendment, modification or termination in accordance with any provision hereof, by operation of law, by filing with and approval by the state Department of Managed Health Care. This can also be done by mutual written agreement between **HMO** and **Contract Holder** without the consent of **Members**.
- N. **HMO** may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this **EOC**.
- O. No agent or other person, except an authorized representative of **HMO**, has authority to waive any condition or restriction of this **EOC**, to extend the time for making a payment, or to bind **HMO** by making any promise or representation or by giving or receiving any information. No change in this **EOC** shall be valid unless evidenced by an endorsement to it signed by an authorized representative.
- P. This **EOC**, including the Schedule of Benefits, any Riders, and any amendments, endorsements, inserts, or attachments, constitutes the entire **EOC** between the parties hereto pertaining to the subject matter hereof and supersedes all prior and contemporaneous arrangements, understandings, negotiations and discussions of the parties with respect to the subject matter hereof, whether written or oral; and there are no warranties, representations, or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth in this **EOC**. No supplement, modification or waiver of this **EOC** shall be binding unless executed in writing by authorized representatives of the parties.

- Q. This **EOC** has been entered into and shall be construed according to applicable state and federal law.
- R. The Public Policy Committee is a panel of representatives from employer groups, **HMO Members**, the Board of Directors and the **HMO's** Medical Director. The committee meets on a quarterly basis to discuss policies and issues of concern to **Members**. For additional information about the committee, please direct inquiries to Member Services at 1-800-756-7039.
- S. From time to time **HMO** may offer or provide **Members** access to discounts on health care related goods or services. While **HMO** has arranged for access to these goods, services and/or third party provider discounts, the third party service providers are liable to the **Members** for the provision of such goods and/or services. **HMO** is not responsible for the provision of such goods and/or services nor is it liable for the failure of the provision of the same. Further, **HMO** is not liable to the **Members** for the negligent provision of such goods and/or services by third-party service providers. These discounts are subject to modification or discontinuance without notice.

DEFINITIONS

The following words and phrases when used in this **EOC** shall have, unless the context clearly indicates otherwise, the meaning given to them below:

- **Active Course of Treatment.** A planned program of services rendered by a **Physician** or **Provider**, starting on the date a **Physician** first renders a service to correct or treat the diagnosed condition, covering a defined number of services or period of treatment.
- **Active Labor.** Means a labor at a time at which either of the following would occur: a) there is inadequate time to effect safe transfer to another hospital prior to delivery; b) a transfer may pose a threat to the health and safety of the **Member** or the unborn child.
- **Appropriately Qualified.** A **Health Professional**, acting within the scope of their license, who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the **Member**.
- **Behavioral Health Provider.** A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.
- **Complex Imaging Services.** Complex imaging services include: Computerized Axial Tomography (C.A.T. Scans); Magnetic Resonance Imaging (MRIs); Positron Emission Tomography (PET Scans) and any other outpatient diagnostic imaging service costing over \$500.
- **Contract Holder.** An employer or organization who agrees to remit the **Premiums** for coverage under the **Group Agreement** payable to **HMO**. The **Contract Holder** shall act only as an agent of **HMO Members** in the **Contract Holder's** group, and shall not be the agent of **HMO** for any purpose.
- **Contract Year.** A period of 1 year commencing on the **Contract Holder's Effective Date of Coverage** and ends at 12:00 midnight on the last day of the one-year period.
- **Coordination of Benefits.** A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing the authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first. Refer to the Coordination of Benefits section of this **EOC** for a description of the **Coordination of Benefits** provision.

- **Copayment.** A specified dollar amount or percentage required to be paid by or on behalf of a **Member** in connection with benefits, if any, as set forth in the Schedule of Benefits. **Copayments** may be changed by **HMO** upon 30 days' written notice to the **Contract Holder**.
- **Copayment Maximum.** The maximum annual out-of-pocket amount for payment of **Copayments**, if any, to be paid by a **Subscriber** and any **Covered Dependents**, if any.
- **Cosmetic Surgery.** Any non-medically necessary surgery or procedure whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem, but which does not restore bodily function, correct a diseased state, correct disfigurement caused by an accident or birth defect, or correct or naturally improve a physiological function or provide more than a minimal improvement in the appearance of the **Member**. **Cosmetic Surgery** includes, but is not limited to, ear piercing, rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of **Cosmetic Surgery**.
- **Coverage Decision.** The approval or denial of health care services by **HMO** substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of this **EOC**. A **Coverage Decision** is not an **HMO** decision regarding a **Disputed Health Care Service**.
- **Covered Dependent.** Any person in a **Subscriber's** family who meets all the eligibility requirements of the Eligibility and Enrollment section of this **EOC** and the Dependent Eligibility section of the Schedule of Benefits, has enrolled in **HMO**, and is subject to **Premium** requirements set forth in the Premiums section of the **Group Agreement**.
- **Covered Benefits.** Those **Medically Necessary Services** and supplies set forth in this **EOC**, which are covered subject to all of the terms and conditions of the **Group Agreement** and **EOC**.
- **Creditable Coverage.** Coverage of the **Member** under a group health plan (including a governmental or church plan), a health insurance coverage (either group or individual insurance), Medicare, Medicaid, a military-sponsored health care (CHAMPUS), a program of the Indian Health Service, a State health benefits risk pool, the Federal Employees Health Benefits Program (FEHBP), a public health plan, including coverage received under a plan established or maintained by a foreign country or political subdivision as well as one established and maintained by the government of the United States, any health benefit plan under section 5(e) of the Peace Corps Act and the State Children's Health Insurance Program (S-CHIP). **Creditable Coverage** does not include coverage only for accident; Workers' Compensation or similar insurance; automobile medical payment insurance; coverage for on-site medical clinics; or limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits that are provided by a separate policy.
- **Custodial Care.** Services and supplies that are intended to help a **Member** meet their personal needs. Care can be **Custodial Care** even if it is prescribed by a **Physician**, delivered by trained medical personnel, or even if it involves artificial methods (or equipment) such as feeding tubes, monitors, or catheters. Examples of **Custodial Care** include, but are not limited to:
 1. Changing dressings and bandages, periodic turning and positioning in bed, administering oral medication, watching or protecting a **Member**.
 2. Care of a stable tracheostomy, including intermittent suctioning.
 3. Care of a stable colostomy/ileostomy.
 4. Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings.
 5. Care of a stable indwelling bladder catheter, including emptying/changing containers and clamping tubing.
 6. Respite care, adult (or child) day care, or convalescent care.
 7. Helping a **Member** perform an activity of daily living, such as: walking, grooming, bathing, dressing, getting in and out of bed, toileting, eating, or preparing food.

8. Any services that an individual without medical or paramedical training can perform or be trained to perform.
- **Detoxification.** The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed **Physician**, while keeping the physiological risk to the patient at a minimum.
 - **Disputed Health Care Service.** Any health care service eligible for coverage and payment that has been denied, modified, or delayed by a decision of the **HMO**, or one of its contracting **Providers**, in whole or in part due to a finding that the service is not **Medically Necessary**.
 - **Durable Medical Equipment.** Equipment, as determined by **HMO**, which is a) made to withstand prolonged use; b) made for and mainly used in the treatment of a disease or injury; c) suited for use while not confined as an inpatient in the **Hospital**; d) not normally of use to persons who do not have a disease or injury; e) not for use in altering air quality or temperature; and f) not for exercise or training.
 - **Effective Date of Coverage.** The commencement date of coverage under this **EOC** as shown on the records of **HMO**.
 - **Emergency Service(s).** Medical screening, examination and evaluation by a **Physician**, or, to the extent permitted by applicable law, by other **Health Professionals**, to determine if an emergency medical condition, psychiatric emergency medical condition, and/or active labor exists. If such conditions are determined to exist, the care and treatment to relieve or eliminate the emergency medical or psychiatric condition, within the capability of the facility.
 - **Evidence of Coverage/EOC.** This **Evidence of Coverage**, including the Schedule of Benefits, and any riders, amendments, or endorsements, which outlines coverage for a **Subscriber** and **Covered Dependents** according to the **Group Agreement**.
 - **Experimental or Investigational Procedures.** Services or supplies that are, as determined by **HMO**, experimental. A drug, device, procedure or treatment will be determined to be experimental if:
 1. there is not sufficient outcome data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
 2. required FDA approval has not been granted for marketing; or
 3. a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or
 4. the written protocol or protocol(s) used by the treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or
 5. it is not of proven benefit for the specific diagnosis or treatment of a **Member's** particular condition; or
 6. it is not generally recognized by the **Medical Community** as effective or appropriate for the specific diagnosis or treatment of a **Member's** particular condition; or
 7. it is provided or performed in special settings for research purposes.

- **Group Agreement.** The **Group Agreement** between **HMO** and the **Contract Holder**, including the Group Application, Cover Sheet, this **EOC**, the Schedule of Benefits, any Riders, any amendments, any endorsements, and any attachments, as subsequently amended by operation of law and as filed with and approved by the applicable public authority.
- **Health Professional.** A **Physician** or other professional who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides **Medical Services** which are within the scope of the individual's license or certificate.
- **HMO.** Aetna Health of California Inc., a California corporation operating pursuant to Chapter 2.2 of Division 2 of the Health and Safety Code (commencing with Section 1340), commonly known as the Knox-Keene Health Care Service Plan of 1975.
- **Homebound Member.** A **Member** who is confined to the home due to an illness or injury which makes leaving the home medically contraindicated or if the act of transport would be a serious risk to their life or health.

Examples where a **Member** would not be considered homebound are:

1. A **Member** who does not often travel from home because of feebleness and/or insecurity brought on by advanced age (or otherwise).
 2. A wheelchair-bound **Member** who could safely be transported via wheelchair accessible transport.
- **Home Health Services.** Those items and services provided by **Participating Providers** as an alternative to hospitalization, and approved and coordinated in advance by **HMO**.
 - **Hospice Care.** A program of care that is provided by a **Hospital**, **Skilled Nursing Facility**, hospice, or a duly licensed **Hospice Care** agency, and is approved by **HMO**, and is focused on a palliative rather than curative treatment for **Members** who have a medical condition and a prognosis of less than 12 months to live.
 - **Hospital(s).** An institution rendering inpatient and outpatient services, accredited as a **Hospital** by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by **HMO** as meeting reasonable standards. A **Hospital** may be a general, acute care, rehabilitation or specialty institution.
 - **Infertile or Infertility.** The condition of a presumably healthy **Member** who is unable to conceive or produce conception after a period of 1 year of timed, unprotected coitus, or 12 cycles of artificial insemination (for **Members** less than 35 years of age), or 6 months or more of timed unprotected coitus, or 6 cycles of artificial insemination (for **Members** age 35 years of age or older). **Infertile or Infertility** does not include conditions for male **Members** when the cause is a vasectomy or orchiectomy or for female **Members** when the cause is a tubal ligation or hysterectomy.
 - **Inquiry.** A **Member's** request for administrative service, information, or to express an opinion, including but not limited to, claims regarding scope of coverage for health services, denials, cancellations, terminations or renewals, and the quality of services provided.
 - **Institute of Excellence™ (IOE).** One of a network of facilities specifically contracted with by **HMO** to provide certain **Transplants** to **Members**. A facility is considered a **Participating Provider** only for those types of **Transplants** for which it has been specifically contracted.
 - **Life-Threatening Or Seriously Debilitating Condition.** A disease or condition (including the diagnosis of HIV or AIDS):
 1. where the likelihood of death is high unless the course of the disease is interrupted;
 2. with potentially fatal outcome, where the end point of clinical intervention is survival; or
 3. that causes major irreversible morbidity.

- **Medical Community.** A majority of **Physicians** who are Board Certified in the appropriate specialty.
- **Medical and Scientific Evidence** means any as listed below:
 1. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
 2. Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database Health Services Technology Assessment Research (HSTAR);
 3. Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
 4. The following standard reference compendia: The American Hospital Formulary Service-Drug Information, the American Association of Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;
 5. Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the Federal Agency of Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purposes of evaluating the medical value of health services;
 6. Peer-reviewed abstracts accepted for presentation at major medical association meetings.
- **Medical Emergency.** The existence of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.
- **Medical Services.** The professional services of **Health Professionals**, including medical, surgical, diagnostic, therapeutic, preventive care and birthing facility services.
- **Medically Necessary, Medically Necessary Services, or Medical Necessity.** Health care services and supplies that a **Physician**, other health care provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating a condition, illness, injury, disease or its symptoms, and that provision of the service or supply is:
 - In accordance with generally accepted standards of medical or health care practice;
 - Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's condition, illness, injury or disease; and
 - Not primarily for the convenience of the patient, **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 that patient's condition, illness, injury, or disease.

This definition applies only to the determination by **HMO** of whether health care services are **Covered Benefits** under this **EOC**.

- **Member(s).** A **Subscriber** or **Covered Dependent** as defined in this **EOC**.

- **Mental Illness.** An illness commonly understood to be a mental disorder, whether or not it has a physiological or organic basis, and for which treatment is generally provided by or under the direction of a **Behavioral Health Provider** such as a psychiatric **Physician**, a psychologist or a psychiatric social worker.

The following conditions are considered a **Mental Illness** under this plan:

- Anorexia/Bulimia Nervosa.
- Bipolar disorder.
- Major depressive disorder.
- Obsessive compulsive disorder.
- Panic disorder.
- Pervasive Mental Developmental Disorder (including Autism).
- Psychotic Disorders/Delusional Disorder.
- Schizo-affective Disorder.
- Schizophrenia.

Also included is any other mental condition which requires **Medically Necessary** treatment.

- **National Medical Excellence Program.** Coordinating **HMO** services team for **Transplant** services and other specialized care.
- **Non-Hospital Facility.** A facility, licensed by the appropriate regulatory authority, for the care or treatment of alcohol or drug dependent persons or mental illness treatment program, except for transitional living facilities.
- **Open Enrollment Period.** A period each calendar year, when eligible employees of the **Contract Holder** may enroll in **HMO** without a waiting period or exclusion or limitation based on health status or, if already enrolled in **HMO**, may transfer to an alternative health plan offered by the **Contract Holder**.
- **Partial Hospitalization.** The provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a **Hospital** or **Non-Hospital Facility** which is licensed as an alcohol or drug abuse or mental illness treatment program by the appropriate regulatory authority, and which is designed for a patient or client who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care.
- **Participating.** A description of a **Provider** that has entered into a contractual agreement with **HMO** for the provision of services to **Members**.
- **Participating Infertility Specialist.** A **Specialist** who has entered into a contractual agreement with **HMO** for the provision of **Infertility** services to **Members**.
- **Pervasive Developmental Disorders.** Include Autistic Disorder, Rett's disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified (including Atypical Autism), in accordance with the Diagnostic and Statistical Manual for Mental Disorders –IV - Text Revision (June 2000).
- **Physician.** A duly licensed member of a medical profession, who has an M.D. or D.O. degree, who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides **Medical Services** which are within the scope of the individual's license or certificate.
- **Premium.** The amount the **Contract Holder** or **Member** is required to pay to **HMO** to continue coverage.
- **Primary Care Physician (PCP).** A **Participating Physician** who supervises, coordinates and provides initial care and basic **Medical Services** as a general or family care practitioner, or in some cases, as an

internist, obstetrician, gynecologist or a pediatrician to **Members**, initiates their **Referral** for **Specialist** care, and maintains continuity of patient care.

- **Provider(s).** A **Physician, Health Professional, Hospital, Skilled Nursing Facility**, home health agency or other recognized entity or person licensed to provide **Hospital** or **Medical Services** to **Members**.
- **Reasonable Charge.** The charge for a **Covered Benefit** which is determined by the **HMO** to be the prevailing charge level made for the service or supply in the geographic area where it is furnished. **HMO** may take into account factors such as the complexity, degree of skill needed, type or specialty of the **Provider**, range of services provided by a facility, and the prevailing charge in other areas in determining the **Reasonable Charge** for a service or supply that is unusual or is not often provided in the area or is provided by only a small number of providers in the area.
- **Reconstructive Surgery.** Surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: a) improve function and b) create a normal appearance, to the extent possible.
- **Referred Benefits.** **Covered Benefits** under the **HMO EOC** received from **Participating Providers** upon prior **Referral** issued by the **Member's HMO Primary Care Physician**.
- **Referral.** Specific directions or instructions from a **Member's PCP**, in conformance with **HMO's** policies and procedures, that direct a **Member** to a **Participating Provider** for **Medically Necessary** care.
- **Residential Treatment Facility – (Mental Disorders)**

This is an institution that meets all of the following requirements:

- On-site licensed **Behavioral Health Provider** 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a **Physician**.
- Has access to necessary medical services 24 hours per day/7 days a week.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a **Psychiatrist** or psychologist for individual psychotherapy.
- Has peer-oriented activities.
- Services are managed by a licensed **Behavioral Health Provider** who, while not needing to be individually contracted, needs to (1) meet the **HMO** credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

- **Residential Treatment Facility – (Alcoholism and Drug Abuse)**

This is an institution that meets all of the following requirements:

- On-site licensed **Behavioral Health Provider** 24 hours per day/7 days a week
 - Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
 - Is admitted by a **Physician**.
 - Has access to necessary medical services 24 hours per day/7 days a week.
 - If the **Member** requires detoxification services, must have the availability of on-site medical treatment 24 hours per day/7 days a week, which must be actively supervised by an attending **Physician**.
 - Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
 - Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
 - Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
 - Provides access to at least weekly sessions with a **Psychiatrist** or psychologist for individual psychotherapy.
 - Has peer-oriented activities.
 - Services are managed by a licensed **Behavioral Health Provider** who, while not needing to be individually contracted, needs to (1) meet the **HMO** credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
 - Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
 - Provides a level of skilled intervention consistent with patient risk.
 - Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
 - Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.
 - Ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally.
 - 24-hours per day/7 days a week supervision by a **Physician** with evidence of close and frequent observation.
 - On-site, licensed **Behavioral Health Provider**, medical or substance abuse professionals 24 hours per day/7 days a week.
- **Respite Care.** Care furnished during a period of time when the **Member's** family or usual caretaker cannot, or will not, attend to the **Member's** needs.
 - **Serious Emotional Disturbances of a Child.** A mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. A "child" is a minor under the age of 18. **Serious Emotional Disturbances of a Child** include but are not limited to: (a) psychotic features, (b) risk of suicide, and (c) risk of violence due to a mental disorder.
 - **Serious Mental Illness (Severe Mental Illness).** Includes the following conditions that meet the diagnostic criteria described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders: (a) schizophrenia, (b) schizoaffective disorder, (c) bipolar disorder, (d) major depressive disorders, (e) panic disorder, (f) obsessive-compulsive disorder, (g) **Pervasive Developmental Disorders** or autism, (h) anorexia nervosa, or (i) bulimia nervosa.
 - **Service Area.** The geographic area, established by **HMO** and approved by the appropriate regulatory authority.

- **Skilled Nursing.** Services that require the medical training of and are provided by a licensed nursing professional and are not **Custodial Care**.
- **Skilled Nursing Facility.** An institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing **Skilled Nursing** care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. **Skilled Nursing Facility** does not include institutions which provide only minimal care, **Custodial Care** services, ambulatory or part-time care services, or institutions which primarily provide for the care and treatment of mental illness and substance abuse. The facility must qualify as a **Skilled Nursing Facility** under Medicare or as an institution accredited by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association, the Commission on the Accreditation of Rehabilitative Facilities, or as otherwise determined by the health insurer to meet the reasonable standards applied by any of the aforesaid authorities. Examples of **Skilled Nursing Facilities** include Rehabilitation Hospitals (all levels of care, e.g. acute) and portions of a **Hospital** designated for Skilled or Rehabilitation services.
- **Specialist.** A **Physician** who provides medical care in any generally accepted medical or surgical specialty or subspecialty.
- **Specialty Care Center.** Center that is accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.
- **Standing Referral.** A **Referral** by a **PCP** to a **Specialist** for more than one visit to the specialist, as indicated in the treatment plan, if any, without the **PCP** having to provide a specific **Referral** for each visit.
- **Subscriber.** A person who meets all applicable eligibility requirements as described in this **EOC** and on the Schedule of Benefits, has enrolled in **HMO**, and is subject to **Premium** requirements as set forth in the Premiums section of the **Group Agreement**.
- **Substance Abuse.** Any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.
- **Substance Abuse Rehabilitation.** Services, procedures and interventions to eliminate dependence on or abuse of legal and/or illegal chemical substances, according to individualized treatment plans.
- **Transplant.** Replacement of solid organs; stem cells; bone marrow or tissue.
- **Transplant Occurrence.** Considered to begin at the point of authorization for evaluation for a **Transplant**, and end: (1) 365 days from the date of the **Transplant**; or (2) upon the date the **Member** is discharged from the **Hospital** or outpatient facility for the admission or visit(s) related to the **Transplant**, whichever is later.
- **Traveling Companion.** A person whose presence as a companion or caregiver is necessary to enable a **Member** to receive services in connection with a **Transplant** on an inpatient or outpatient basis; or to travel to and from the **IOE** facility where treatment is provided.
- **Totally Disabled or Total Disability.** A **Member** shall be considered **Totally Disabled** if:
 1. the **Member** is a **Subscriber** and is prevented, because of injury or disease, from performing any occupation for which the **Member** is reasonably fitted by training, experience, and accomplishments; or

2. the **Member** is a **Covered Dependent** and is prevented because of injury or disease, from engaging in substantially all of the normal activities of a person of like age and sex in good health.
- **Urgent Care.** Non-preventive or non-routine health care services which are **Covered Benefits** and are required in order to prevent serious deterioration of a **Member's** health following an unforeseen illness, injury or condition if: (a) the **Member** is temporarily absent from the **HMO Service Area** and receipt of the health care service cannot be delayed until the **Member** returns to the **HMO Service Area**; or (b) the **Member** is within the **HMO Service Area** and receipt of the health care services cannot be delayed until the **Member's Primary Care Physician** is reasonably available. **Urgent Care** includes maternity services necessary to prevent serious deterioration of the health of the **Member** or the **Member's** fetus, based on the **Member's** reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the **Member** returns to the **HMO Service Area**.

**AETNA HEALTH OF CALIFORNIA INC.
(CALIFORNIA)**

ENROLLMENT ENDORSEMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health of California Inc. **EOC** is hereby amended as follows:

ELIGIBILITY AND ENROLLMENT

The Eligibility and Enrollment section of the **EOC** is amended to include the following:

Employees will be permitted to enroll in **HMO** at any time during the year provided the circumstances surrounding the enrollment involve a "Life Event" occurrence and the enrollment form is received by **HMO** within 31 days of when the event occurs.

"Life Events" are limited to:

- a marriage or divorce of the employee;
- the death of the employee's spouse or a dependent;
- the birth, proposed adoption or adoption of a child of the employee;
- the termination or commencement of employment of the employee's spouse;
- the switching from part-time to full-time employment status or from full-time to part-time status by the employee or employee's spouse;
- the taking of an unpaid leave of absence of the employee or employee's spouse;
- a significant change in health coverage of employee or spouse attributable to spouse's employment.

**AETNA HEALTH OF CALIFORNIA INC.
(CALIFORNIA)**

MEDICAL LEAVE OF ABSENCE FROM SCHOOL

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health of California Inc. **Evidence of Coverage (EOC)** is amended as follows:

Section 4 of Part B. Enrollment under the **ELIGIBILITY AND ENROLLMENT** provision is amended by the addition of Item c.

c. Medical Leave of Absence from School.

Coverage is available for a **Covered Dependent** child who takes a medical leave of absence from a secondary or post-secondary educational institution as long as the child does not meet the requirements described in the preceding ***Physically and Mentally Disabled Dependent Children*** provision. In addition, the child must be:

- Over 18 years of age; and
- Enrolled as a full-time student.

The medical leave of absence will begin on the earlier of:

- The first day of the medical leave of absence from school; or
- The date the **Physician** determines the illness prevented the dependent child from attending school.

Any break in the school calendar shall not disqualify the dependent child from coverage under this section.

Documented or certified proof as to the **Medical Necessity** for the leave of absence from school must be submitted to **HMO** no later than:

- 30 days *prior* to the medical leave of absence from the school, if the medical reason for the absence and the absence are foreseeable; or
- 30 days *after* the start date of the medical leave of absence from school.

A dependent student's coverage will end under this section when the first of the following occurs:

- Twelve (12) months from the date the medical leave of absence began;
- He or she no longer meets the plan's definition of "dependent;"
- Dependent coverage is discontinued under the group contract;
- He or she becomes eligible for comparable benefits under this plan or any other group plan or policy; or
- Any required contributions toward your or your dependent's coverage stops.

**AETNA HEALTH OF CALIFORNIA INC.
(CALIFORNIA)**

**EVIDENCE OF COVERAGE AND SCHEDULE OF BENEFITS
HEALTH CARE REFORM AMENDMENT**

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health of California Inc. **Evidence of Coverage (EOC)** is hereby amended as follows:

HMO based plans - **IMPORTANT:** Can you read this Amendment? If not, we can have somebody help you read it. You may also be able to get this Amendment written in your language. For free help, please call right away at 1-877-287-0117.

Planes basados en HMO - **IMPORTANTE:** ¿Puede leer esta Enmienda? En caso de no poder leerla, le brindamos nuestra ayuda. También puede obtener esta Enmienda escrita en su idioma. Para obtener ayuda gratuita, por favor llame de inmediato al 1-877-287-0117.

- The eligibility rules for **Covered Dependents** in the Eligibility and Enrollment section of the **EOC** and the Dependent Eligibility section of the Schedule of Benefits have been changed. A child will now be eligible to enroll if he or she is under 26 years of age. Any rule that they be a full-time student, not married or chiefly dependent upon the **Subscriber** for support will not apply. All other dependent eligibility rules still apply.

If the **Subscriber** has a child that can now be enrolled, the **Subscriber** may contact Member Services for details.

Covered Benefits for a **Covered Dependent** who is not capable of self-support due to mental or physical disability will be continued past the maximum age for a child.

- The following Preventive Care services are **Covered Benefits**, and will be paid at 100% with no cost-sharing such as **Copayment**, **Deductibles** and dollar maximum benefits:
 - Routine Adult Physical Examinations (including immunizations, routine vision and hearing screenings);
 - Routine Well Child Care (including immunizations);
 - Routine Cancer Screenings (which include Screening Mammograms; Prostate Specific Antigen (PSA) Tests; Digital-Rectal Exams (DRE); Fecal Occult Blood Tests (FOBT); Sigmoidoscopies; Double Contrast Barium Enemas (DCBE) and Colonoscopies); and
 - Routine Gynecological Exams, including routine Pap smears.

These benefits will be subject to age; family history; and frequency guidelines. The guidelines will be determined by applying the more generous rules, as they apply to the **Member**, as set forth in:

- the most recently published preventive health care guidelines as required by the Federal Department of Health and Human Services; or
 - the state laws and regulations that govern the **Group Agreement**.
- Any calendar year; **Contract Year**; or lifetime dollar maximum benefit that applies to an "Essential Service" (as defined by the Federal Department of Health and Human Services) listed below, no longer applies.

Essential Services (as defined by the Federal Department of Health and Human Services) will continue to be subject to any **Copayments**, **Deductibles** and other types of maximums (e.g., day and visit), **Referral**

and pre-authorization rules, and exclusions and limitations that apply to these **Covered Benefits** as indicated in the **EOC and Schedule of Benefits**, including any amendments or riders.

Essential Services include the following:

- Diagnostic X-Ray and Laboratory Testing;
- **Emergency Services** (including medical transportation during a **Medical Emergency**);
- **Home Health Care**;
- Infusion Therapy;
- Injectable Medications;
- Inpatient **Hospital**;
- Maternity Care and Related Newborn Care;
- **Mental Health** (inpatient and outpatient);
- **Substance Abuse** (inpatient and outpatient);
- Outpatient Prescription Drug Rider benefits;
- Outpatient **Surgery** (when performed at a **Hospital** Outpatient Facility or at a facility other than a **Hospital** Outpatient Facility, including **Physician's** office visit surgery when performed by a **PCP** or **Specialist**);
- **Primary Care Physician (PCP)** and **Specialist Physician** Office Visits (including **E-visits**);
- Prosthetic Devices;
- **Skilled Nursing Facility**;
- Short Term Outpatient Rehabilitation Therapies (cognitive, occupational, physical and speech);
- **Transplants** (facility and non-facility);
- **Urgent Care**; and
- **Walk-in Clinic** visits.

THE ABOVE ESSENTIAL SERVICES MAY NOT BE **COVERED BENEFITS** UNDER THE **MEMBER'S EOC**. **MEMBERS** SHOULD REFER TO THEIR **EOC** FOR A COMPLETE LIST OF **COVERED BENEFITS** AND EXCLUSIONS AND LIMITATIONS.

- If a **Member's** coverage in the **EOC** is terminated as a result of fraud or intentional misrepresentation of material fact, **HMO** will provide the **Member** with a 30-day advance written notice prior to the date of the termination.
- Section B. shown in **Appeals of Adverse Benefit Determinations** under the **Claims Procedures** provision of the **EOC** is amended by the addition of the following paragraphs:

A **Member** may be allowed to provide evidence or testimony during the **Appeal** process in accordance with the guidelines established by the Federal Department of Health and Human Services.

Also, at the request of a **Member**, **HMO** must provide the **Member** with all documents, records, and other information relied upon or generated during the consideration of a claim.

- Any **Member** who is not proficient in the English language should call our Language Assistance Line at 1-877-287-0117 in order to obtain any applicable notices in his/her primary language that describe the Appeals Process for Internal and External Reviews.

Services of an Interpreter to provide verbal assistance are also available if or when needed by calling the phone number shown above.

**AETNA HEALTH OF CALIFORNIA INC.
(CALIFORNIA)**

EVIDENCE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health of California Inc. **Evidence of Coverage (EOC)** is hereby amended as follows:

The **Definitions** section of the **EOC** is hereby amended to add the following definition:

- **Surgery or Surgical Procedure.** The diagnosis and treatment of injury, deformity and disease by manual and instrumental means, such as cutting, abrading, suturing, destruction, ablation, removal, lasering, introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy), correction of fracture, reduction of dislocation, application of plaster casts, injection into a joint, injection of sclerosing solution, or otherwise physically changing body tissues and organs.

**AETNA HEALTH OF CALIFORNIA INC.
(CALIFORNIA)**

PRESCRIPTION LENS RIDER

Contract Holder Group Agreement Effective Date: January 1, 2013

Aetna Health of California Inc. ("**HMO**") and **Contract Holder** agree to offer to **Members** the **HMO** Prescription Lens plan, subject to the following provisions:

The Covered Benefits section of the **Evidence of Coverage (EOC)** is amended to add the following coverage:

- **Lens Reimbursement Benefits.**

Member is eligible for an allowance up to \$100 for the purchase of prescription lenses and frames (including prescription contact lenses). This allowance is payable once in each 24 month period commencing with the date of **Member's** initial use of this benefit.

Member will be reimbursed for the amount of this allowance. However, if the prescription lenses or frames are purchased from select **Providers** who have an agreement with **HMO** to bill **HMO** directly, the allowance will be directly deducted from the cost of the prescription lenses or frames.

The last paragraph shown in Paragraph **K Conversion Privilege** – Item 1. is hereby amended by the addition of the following sentence:

The conversion privilege does not apply to the Prescription Lens Reimbursement Rider.

**AETNA HEALTH OF CALIFORNIA INC.
(CALIFORNIA)**

PEDIATRIC ASTHMA SUPPLIES AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health of California Inc. **Evidence of Coverage (EOC)** is hereby amended as follows:

The following item is added to **Section F. Additional Benefits** of the **Prescription Plan Rider**:

- **Pediatric Asthma Supplies.**

The following pediatric asthma supplies are covered if **Medically Necessary** upon prescription or upon **Participating Physician's** order only at **Participating Retail** or **Mail Order Pharmacy**. The **Member** must pay a separate **Copayment** for each item.

1. Inhaler spacers and
2. Peak flow meters.

In the event that Nebulizers (including face masks and tubing) are needed, they will be payable on the same basis as any **Covered Benefit** for **Durable Medical Equipment**.

In an emergency situation, or when the **Member** is traveling outside of the **HMO Service Area**, a prescription for inhaler spacers will be covered even if filled at a **Non-Participating Retail Pharmacy**.

**AETNA HEALTH OF CALIFORNIA INC.
(CALIFORNIA)**

PRESCRIPTION PLAN RIDER

Group Agreement Effective Date: January 1, 2013

HMO and **Contract Holder** agree to provide to **Members** the **HMO** Prescription Plan Rider, subject to the following provisions:

DEFINITIONS

The Definitions section of the **EOC** is amended to include the following definitions:

- **Brand Name Prescription Drug(s).** Prescription drugs and insulin with a proprietary name assigned to it by the manufacturer or distributor and so indicated by MediSpan or any other similar publication designated by **HMO** or an affiliate. **Brand Name Prescription Drugs** do not include those drugs classified as **Generic Prescription Drugs** as defined below.
- **Contracted Rate.** The negotiated rate between **HMO** or an affiliate and the **Participating Retail or Mail Order Pharmacy**.
- **Drug Formulary.** A list of prescription drugs and insulin established by **HMO**, which includes both **Brand Name Prescription Drugs** and **Generic Prescription Drugs**. This list is subject to periodic review and modification by **HMO**. The Pharmacy and Therapeutics Committee reviews the Formulary at least twice a year. Throughout the year the Pharmacy and Therapeutics Committee may evaluate new drugs once they are approved by the FDA, and may re-evaluate the drugs on the current formulary in light of new FDA, manufacturer and peer reviewed information. Further information about the Drug Formulary and the Pharmacy and Therapeutics Committee is located in the "The Formulary Guide" section. A copy of the **Drug Formulary** will be available at any time upon request by the **Member** or may be accessed at the pharmacy website, at www.aetna.com.
- **Drug Formulary Exclusions List.** A list of prescription drugs excluded from the **Drug Formulary**, subject to change from time to time. **The prescription drugs on the Drug Formulary Exclusions List are not excluded from coverage.** Prescription drugs on the **Drug Formulary Exclusions List** will be covered at the highest **Copayment**.
- **Generic Prescription Drug(s).** Prescription drugs and insulin, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by MediSpan or any other similar publication designated by **HMO**.
- **Non-Formulary Prescription Drug(s).** A product or drug not listed on the **Drug Formulary** which includes drugs listed on the **Drug Formulary Exclusions List**. **Non-Formulary Prescription Drugs** are covered under this rider without **Prior Authorization** at the highest **Copayment**.
- **Participating Mail Order Pharmacy.** A pharmacy which has contracted with **HMO** to provide covered outpatient prescription drugs or medicines and insulin to **Members** by mail or other carrier.
- **Participating Retail Pharmacy.** A community pharmacy which has contracted with **HMO** to provide covered outpatient prescription drugs to **Members**.

- **Prior Authorization:** An expeditious process by which prescribing **Providers** may obtain authorization for **Medically Necessary** outpatient prescription drugs. **Prior Authorization** includes:
 - **Precertification Program.** For certain outpatient prescription drugs listed on the Precertification List, prescribing **Physicians** must contact **HMO** to request **Prior Authorization (Precertification)** for such drugs. The list of drugs requiring **Precertification** is subject to change by **HMO**. An updated copy of the list of drugs requiring **Precertification** is available upon request by the **Member** or may be accessed at the pharmacy website, at www.aetna.com.
 - **Step Therapy Program.** A form of **Prior Authorization** under which selected prescription drugs will not be covered until a **Member** tries an alternative prescription drug which **HMO** determined will be as clinically effective as the original prescribed drug. The list of prescription drugs subject to the program is subject to change by **HMO**. An updated copy of the list of drugs subject to the program is available upon request by the **Member** or may be accessed at the pharmacy website, at www.aetna.com. Prescription drugs subject to the program will be covered at the applicable copay without a trial of a first line therapy drug, as medically necessary, if the prescribing **Physician** obtains **Prior Authorization**.

COVERED BENEFITS

The Covered Benefits section of the **EOC** is amended to add the following provision:

A. Outpatient Prescription Drug Benefit

Medically Necessary outpatient prescription drugs and insulin are covered when prescribed by a **Provider** licensed to prescribe federal legend prescription drugs or medicines subject to the terms, **HMO** policies, Exclusions and Limitations section described in this rider and the **EOC**. Coverage is based on **HMO's** determination that a prescription drug is **Medically Necessary**. Some items are covered only with **Precertification** from **HMO**. Items covered by this rider are subject to drug utilization review by **HMO** and/or **Member's Participating Provider** and/or **Member's Participating Retail or Mail Order Pharmacy**.

Non-emergency and non-**Urgent Care** prescriptions will be covered only when filled at a **Participating Retail Pharmacy** or the **Participating Mail Order Pharmacy**. **Members** are required to present their ID card at the time the prescription is filled and pay the applicable **Copayment**. **Members** who have lost or misplaced their ID Card may call Member Services at 1-800-756-7039 for a replacement card and for pharmacy authorizations. A **Member** who fails to identify themselves as covered by presenting the ID card, or requesting that the **Participating Retail Pharmacy** contact **HMO** for verification of coverage will not receive reimbursement for the entire amount of out-of-pocket expenses. **HMO** will deduct any applicable **Copayments**, and will reimburse the member for the **Contracted Rate** for the prescription. Please refer to the **EOC** for a description of emergency and **Urgent Care** coverage. **HMO** retains the right to review all requests for reimbursement and make reimbursement determinations subject to the Claim Procedures/Complaints and Appeals section of the **EOC**.

Precertification: Certain prescription drugs on the **Precertification** List are covered only when **Precertified** by **HMO**. **Member's Participating Physician** or **Participating Retail or Mail Order Pharmacy** (for certain antibiotics) may request **Precertification** to obtain coverage for drugs on the **Precertification** List.

Prescription drugs on the **Step Therapy Program** list will be covered if **Member's** prescribing **Provider** requests **Prior Authorization**.

Such **Precertification** or **Prior Authorization** requests shall be made by the **Provider** to the precertification department of **HMO's** Pharmacy Management Department. The Pharmacy Management Department will respond to complete **Precertification/Prior Authorization** requests within 24 hours of receipt, based upon the nature of the member's medical condition. Coverage granted as a result of **Precertification/Prior Authorization** shall be based on an individual, case by case **Medical Necessity** determination and coverage will not apply or extend to other **Members**. The Complaint and Appeals/Independent Medical Review processes described in the **EOC** may be utilized by **Members** if they disagree with the determination made with regard to a **Precertification/Prior Authorization** request.

- B. Each prescription is limited to a maximum 30 day supply when filled at a **Participating Retail Pharmacy** or 90 day supply when filled by the **Participating Retail** or **Mail Order Pharmacy** designated by **HMO**. Except in an emergency or **Urgent Care** situation, or when the **Member** is traveling outside the **HMO Service Area**, prescriptions must be filled at a **Participating Retail** or **Mail Order Pharmacy**. Coverage of prescription drugs may be subject to the **Precertification Program** and the **Step Therapy Program**.

- C. FDA approved prescription drugs are covered when the off-label use of the drug has not been approved by the FDA for that indication, only when such drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information), or the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized, major peer reviewed journal. Coverage of off label use of these drugs may be subject to the **Precertification Program** and the **Step Therapy Program**.

- D. **Emergency Prescriptions** - Emergency prescriptions are covered subject to the following terms:

When a **Member** needs a prescription filled in an emergency or **Urgent Care** situation, or when the **Member** is traveling outside of the **HMO Service Area**, **HMO** will reimburse the **Member** as described below.

When a **Member** obtains an emergency or out-of-area **Urgent Care** prescription at a non-**Participating Retail Pharmacy**, **Member** must directly pay the pharmacy in full for the cost of the prescription. **Member** is responsible for submitting a request for reimbursement in writing to **HMO** with a receipt for the cost of the prescription. Reimbursement requests are subject to professional review by **HMO** to determine if the event meets **HMO's** requirements. Upon approval of the claim, **HMO** will directly reimburse the **Member** 100% of the cost of the prescription, less the applicable **Copayment** specified in the Copayments section of this Rider. Coverage for items obtained from a non-**Participating** pharmacy is limited to items obtained in connection with covered emergency and out-of-area **Urgent Care** services. **Members** must access a **Participating Retail Pharmacy** for **Urgent Care** prescriptions inside the **HMO Service Area**.

When a **Member** obtains an emergency or **Urgent Care** prescription at any **Participating Retail Pharmacy**, including an out-of-area **Participating Retail Pharmacy**, **Member** will pay to the **Participating Retail Pharmacy** the **Copayment(s)** specified in the Copayments section of this Rider. **Members** are required to present their ID card at the time the prescription is filled. **HMO** will not cover claims submitted as a direct reimbursement request from a **Member** for a prescription purchased at a **Participating Retail Pharmacy** except upon professional review and approval by **HMO**. **Members** must access a **Participating Retail Pharmacy** for **Urgent Care** prescriptions inside the **HMO Service Area**.

- E. **Mail Order Prescription Drugs.** Subject to the terms and limitations set forth in this rider, **Medically Necessary** outpatient Prescription drugs are covered when dispensed by the

Participating Mail Order Pharmacy designated by **HMO** and when prescribed by a **Provider** licensed to prescribe federal legend prescription drugs. Outpatient prescription drugs will not be covered if dispensed by a **Participating Mail Order Pharmacy** in quantities that are less than a 31 day supply or more than a 90 day supply (if the **Provider** prescribes such amounts).

F. **Additional Benefits.**

The following prescription drugs, medicines, and supplies are also covered subject to the terms described in this rider:

- **Diabetic Supplies.**

The following diabetic supplies are covered if **Medically Necessary** upon prescription or upon **Physician's** order only at a **Participating Retail or Mail Order Pharmacy**. The **Member** must pay applicable **Copayments** as described in the Copayments section below.

1. Diabetic needles/syringes.
2. Test strips for glucose monitoring and/or visual reading.
3. Diabetic test agents.
4. Lancets/lancing devices.
5. Alcohol swabs.

Please refer to the **EOC Covered Benefits Section, Diabetes Treatment**, for a description of additional benefits and coverage for additional supplies.

- **Contraceptives.**

The following contraceptives and contraceptive devices are covered upon prescription or upon the **Participating Physician's** order only at a **Participating Retail or Mail Order Pharmacy**:

1. Oral contraceptives.
2. Diaphragms, 1 per 365 consecutive day period or as **Medically Necessary**.
3. Injectable contraceptives, the prescription plan **Copayment** applies for each vial.
4. Contraceptive patches.
5. Contraceptive rings.
6. Norplant and IUDs are covered, subject to the applicable **Copayment** shown in the Copayment section of this rider. The **Participating Physician** will provide insertion and removal of the device. An office visit **Copayment**, if any, will apply for this service.

If the **Contract Holder** qualifies as a religious employer as defined in California Health and Safety code section 1367.25(b), the **Contract Holder** has the right to exclude coverage for contraceptive drugs and devices under this **Rider**. If the **Contract Holder** has chosen to exclude such coverage, the contraceptive benefits listed above are not covered under this Plan. **Contract Holders** who exclude coverage for contraceptives are required by law to provide prospective enrollees prior to enrollment with the plan, written notice of such exclusion listing the contraceptive health care services the employer refuses to cover for religious reasons. **Members** should consult their employer (**Contract Holder**) if they have any questions about coverage for contraceptive drugs and devices.

G. **Copayments:**

Member is responsible for the **Copayments** specified in this rider. The **Copayment**, if any, is payable directly to the **Participating Retail or Mail Order Pharmacy** for each prescription or refill at the time the prescription or refill is dispensed. If the **Member** obtains more than a 30 day supply of prescription drugs, medicines, or supplies at the **Participating Mail Order Pharmacy**, not to exceed a 90 day supply, 2 **Copayments** are payable for each supply dispensed. The **Copayment** does not apply to the Maximum Out-of-Pocket Limit shown in the Schedule of Benefits for the medical plan, if any.

Prescription Drug/Medicine Quantity	Generic Formulary Prescription Drugs	Brand Name Formulary Prescription Drugs	Non-Formulary Prescription Drugs
Less than a 31 day supply	\$20	\$35	\$50

H. **The Formulary Guide** contains drugs that have been reviewed by Aetna Health of California Inc. Pharmacy and Therapeutics (P&T) Committee. The P&T Committee reviews the entire Formulary Guide at least twice a year. The P&T Committee reviews information from a variety of sources, including peer review journals and other independently developed materials. Using this information, the P&T Committee periodically evaluates the therapeutic effectiveness of prescription medications and places them into one of three categories:

- Category I The drug represents an important therapeutic advance.
- Category II The drug is therapeutically similar to other available products.
- Category III The drug has significant disadvantages in safety or efficacy when compared to other similar products.

The drugs in Category I are always included on the **Drug Formulary**, and the drugs placed in Category III are not included on the **Drug Formulary**. For therapeutically similar drugs in Category II, **HMO** selects drugs for the Formulary based on the recommendations of the P&T Committee, the cost effectiveness of the medication, and other factors.

A copy of the **Drug Formulary**, or information about the availability of a specific drug may be requested by calling 1-888-792-8742 or the **Drug Formulary** may be accessed through our Internet website at www.aetna.com. Be aware that the presence of a drug on the **Drug Formulary** does not guarantee that a member will receive a prescription for that drug from their prescribing provider for a particular medical condition. **Prior Authorization** or **Precertification**, as explained in The Covered Benefits section of this rider may be necessary for coverage of certain prescription drugs.

EXCLUSIONS AND LIMITATIONS

The Exclusions and Limitations section of the **EOC** is amended to include the following exclusions and limitations:

A. **Exclusions.**

Unless specifically covered under this rider, the following are not covered:

1. Any drug which does not, by federal or state law, require a prescription order (i.e., an over-the-counter (OTC) drug).

2. Any prescription drug for which there is an over-the-counter product which has the identical active ingredient and dosage as the prescription drug. For the purposes of this rider, insulin is not considered an over-the-counter drug.
3. The following are excluded from coverage under the prescription drug rider because they are covered in the Covered Benefits section of the **EOC**.
 - Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by **HMO**. These charges are covered under the **EOC** as part of a **PCP** or **Specialist** office visit. See the Covered Benefits section Primary Care Physician Benefits, or Specialist Physician Benefits.
 - Injectable drugs except for insulin. Please see the Covered Benefits section, Injectable Medications Benefits, of the **EOC**,
 - Syringes and/or needles not dispensed for use with insulin. See the Covered Benefits section Primary Care Physician Benefits, or Specialist Physician Benefits.
 - Any medication which is consumed or administered at the place where it is dispensed, or while a member is a patient in a **Hospital, Non-Hospital Facility, Skilled Nursing Facility, or Specialty Care Center** receiving **Covered Benefits**. However, if a **Member** is an inpatient for non-covered services, for example **Custodial Care** in a **Skilled Nursing Facility**, a **Member**, friend, relative or caregiver on the **Member's** behalf may obtain outpatient prescriptions and provide them to the **Member**. See the Covered Benefits sections, Inpatient Hospital and Skilled Nursing Facility Benefits, or Outpatient Surgery Benefits, of the **EOC**.
 - Immunization or immunological agents, including but not limited to, biological sera, blood, blood plasma or other blood products administered on an outpatient basis, allergy sera and testing materials. See the Covered Benefits section, Inpatient Hospital and Skilled Nursing Facility Benefits, of the **EOC**.
3. Drugs when prescribed for the purpose of weight reduction (e.g., appetite suppressants), including the treatment of obesity. This exclusion does not apply to **Medically Necessary** prescription drugs to treat morbid obesity.
4. Any refill dispensed more than 1 year from the date the latest prescription order was written, or as otherwise permitted by applicable law of the jurisdiction in which the drug is dispensed.
5. Drugs prescribed for uses other than uses approved by the Food and Drug Administration (FDA) under the Federal Food, Drug and Cosmetic Law and regulations, except as described in Section C of this Rider.
6. Any drug labeled "Caution: Limited by Federal Law to Investigational Use", or experimental drugs except as otherwise covered under this rider or under the Covered Benefits section, Clinical Trials, in the **EOC**. Certain **Experimental and Investigative Drugs** may be covered as described in the **EOC**, Covered Benefits, sections Additional Benefits and Clinical Cancer Trials, or as explained in the Exclusions section in the exclusion for **Experimental and Investigative**. The **Member** has the right to appeal a denial based on the determination that a prescription drug is **Experimental or Investigational**, as described in the Complaints and Appeals section of the **EOC**.

7. Medical supplies, devices and equipment and non-medical supplies or substances regardless of their intended use, except as covered in conjunction with Home Health or Hospice Services. Additional information is provided under the Covered Benefits sections, Home Health Benefits, Hospice Benefits, in the **EOC**. This exclusion does not apply to diabetic supplies as listed in this Rider.
8. Injectable drugs used for the purpose of treating **Infertility**, unless otherwise covered by a separate Comprehensive Infertility Rider or ART Rider to the **EOC**.
9. Prescription orders filled prior to the effective date or after the termination date of the coverage provided by this rider.
10. Replacement for lost, stolen or destroyed prescriptions.
11. Drugs or supplies prescribed for the following non-medical conditions: hair growth, cosmetic purposes including anti-aging, improving sexual, athletic and mental performance. This exclusion does not apply to **Medically Necessary Preauthorized** prescription drugs for treatment of diagnosed medical conditions affecting memory including but not limited to Alzheimer's dementia.
12. Prescription drugs and supplies when prescribed in connection with a service or supply which is not a **Covered Benefit** unless required to treat a complication that arises as a result of the service or supply.
13. Drugs dispensed by other than a **Participating Retail** or **Mail Order Pharmacy**, except as **Medically Necessary** for treatment of an emergency or **Urgent Care** condition.
14. Medication packaged in unit dose form when provided for convenience as determined by **HMO**, unless **Medically Necessary** or when medication is not available in any other form. Unit dose form refers to the packaging of prescription drugs so that each prescribed dose is in a separate container. Drugs packaged in unit dose form are typically used in inpatient settings.
15. Nutritional supplements. This exclusion does not apply to formulas and food products for the treatment of PKU as described in the **EOC**, Covered Benefits, Phenylketonuria Benefit.
16. Smoking cessation aids or drugs, except when prescribed for **Medically Necessary** purposes other than smoking cessation.
17. Growth Hormones, except when prescribed as **Medically Necessary**.

B. Limitations:

1. A **Participating Retail** or **Mail Order Pharmacy** may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.
2. **HMO** or an affiliate may have contractual arrangements with drug manufacturers, wholesalers or distributors wherein the **HMO** or an affiliate receives a rebate from the drug manufacturer in connection with certain drugs used by **Members** enrolled in or covered by benefit plans serviced, issued or administered by **HMO** or an affiliate. The **Contracted Rate** and the **Prescription Drug Deductible Amount**, if any do not reflect or include any amount **HMO** or an affiliate may receive under such rebate arrangement.

Notice

Please be aware that administration of the definition of “negotiated charge” for Prescription Drug Expense Coverage for most plans has been changed to support the following:

As to the Prescription Drug Expense Coverage:

The amount **HMO** has established for each **prescription drug** obtained from a **Participating Retail, Mail Order, or Specialty Pharmacy Network Pharmacy**. The **Negotiated Charge** may reflect amounts **HMO** has agreed to pay directly to the **Participating Retail, Mail Order, or Specialty Pharmacy Network Pharmacy**, or to a third party vendor for the prescription drug, and may include an additional service or risk charge set by **HMO**.

The **Negotiated Charge** does not include or reflect any amount **HMO**, an affiliate, or a third party vendor, may receive under a rebate arrangement between **HMO**, an affiliate or a third party vendor and a drug manufacturer for any prescription drug, including prescription drugs on the **Drug Formulary**.

Where permitted by law, this change has been, or will be made to all Member Plan Documents effective as of the first renewal date for the plan occurring after January 1, 2010.

**AETNA HEALTH OF CALIFORNIA INC.
(CALIFORNIA)**

SCHEDULE OF BENEFITS

Plan Name: CITIZEN PLAN

Contract Holder Name: The Government of the District of Columbia

Contract Holder Group Agreement Effective Date: January 1, 2013

Contract Holder Number: 172614

Contract Holder Locations: 363

Contract Holder Service Areas: CA01

Eligibility, **Covered Benefits**, **Medical Necessity**, pre-certification, concurrent review, retrospective record review and all other terms and conditions of your health plan are determined at the sole discretion of Aetna (or its designee). This means that some services recommended by your health professional may not be deemed **Covered Benefits** as determined by Aetna.

If you disagree with Aetna's determination you may appeal the decision and your dispute may be eligible for Independent Medical Review. Consult the **EOC Complaints and Appeals** and **Independent Medical Review** sections for additional information.

BENEFITS

Benefit

Copayment

Maximum Out-of-Pocket Limit

Does not apply to Prescription Drug Benefits.

Individual Limit

\$3,500 per Member per calendar year

Family Limit

\$8,750 per family per calendar year

The family Maximum Out-of-Pocket Limit is a cumulative Maximum Out-of-Pocket Limit for all family members. The family Maximum Out-of-Pocket Limit can be met by a combination of family members with no single individual within the family contributing more than the individual limit.

Maximum Benefit

Unlimited

OUTPATIENT BENEFITS

Benefit

Copayment

Primary Care Physician (PCP) Services

Adult Physical Examination including Immunizations

\$0 per visit

Visits, other than those for immunizations, are subject to the following visit maximum:

Adults 18-65 years old: 1 visit per 12-month period

Adults over 65 years old: 1 visit per 12-month period

Well Child Physical Examination and Immunizations

\$0 per visit

Office Hours Visits

\$10 per visit

After-Office Hours and Home Visits	\$15 per visit
Preventive Care Testing	\$10 per visit
Routine Gynecological Exam(s) 1 visit(s) per 365 day period	\$0 per visit
Specialist Physician Services	\$20 per visit
Prenatal Visit(s) by the attending Obstetrician	\$0 per visit
Outpatient Rehabilitation	\$20 per visit
Treatment over a 60 consecutive day period per incident of illness or injury beginning with the first day of treatment	
Treatment will be provided for each day that is determined to be Medically Necessary as to any physical or mental health condition pursuant to a written treatment plan. Please consult the Covered Benefits Section of the EOC for additional information.	
Outpatient Facility Visits	\$20 per visit
Diagnostic X-Ray Testing	\$0 per visit
Complex Imaging Services, including, but not limited to: Magnetic Resonance Imaging (MRI); Computerized Axial Tomography (CAT); and Positron Emission Tomography (PET)	\$0 per visit
Mammography (Diagnostic)	\$0 per visit
Diagnostic Laboratory Testing	\$0 per visit
Outpatient Emergency Services Hospital Emergency Room or Outpatient Department	\$50 per visit
Urgent Care Facility	\$25 per visit
Ambulance	\$0 per trip
Outpatient Mental Illness Visits	\$10 per visit
Outpatient Substance Abuse Visits Detoxification	\$10 per visit/day
Outpatient Substance Abuse Visits Rehabilitation	\$10 per visit/day
Outpatient Surgery	\$50 per visit
Outpatient Home Health Visits Limited to 3 intermittent visit(s) per day provided by a Participating home health care agency; 1 visit equals a period of 4 hours or less.	
Unlimited visits per calendar year	\$0 per visit

Outpatient Hospice Care Visits	
Unlimited visits per lifetime	\$0 per visit
Injectable Medications	\$10 per visit or per prescription or refill
Medications, supplies and DME provided as part of mandated benefits (for example diabetic supplies)	

INPATIENT BENEFITS

<u>Benefit</u>	<u>Copayment</u>
Acute Care	\$100 per admission
Mental Disorders	
During a Hospital Confinement	\$100 per admission
During a Residential Treatment Facility Confinement	\$100 per admission (waived if a Member is transferred from a Hospital to a Residential Treatment Facility)
Maximum of Unlimited days per calendar year	
Substance Abuse	
Detoxification and Rehabilitation	
During a Hospital Confinement	\$100 per admission
During a Residential Treatment Facility Confinement	\$100 per admission (waived if a Member is transferred from a Hospital to a Residential Treatment Facility)
Maximum of Unlimited days per calendar year	
Maternity	\$100 per admission
Skilled Nursing Facility	
Maximum of 100 days per calendar year	\$100 per admission (waived if a Member is transferred from a Hospital to a Skilled Nursing Facility)
Hospice Care	\$0 per admission (waived if a Member is transferred from a Hospital to a Hospice Care Facility)

ADDITIONAL BENEFITS

<u>Benefit</u>	<u>Copayment</u>
Transplant Benefits	
Transplant Facility Expense Services	\$100 per admission
Routine Eye Exam by a Specialist (including refraction) as per the schedule in the EOC	\$20 per visit
Chiropractic Care Benefits	
20 visits per calendar year	\$15 per visit
Durable Medical Equipment Benefits (DME)	
Copayment	50% (of the cost) per item

DME Maximum Benefit**Unlimited per Member per calendar year**

Copayments for DME provided in conjunction with mandated benefits (for example, insulin pumps for diabetes treatment) apply to the out-of-pocket maximum. DME provided in conjunction with mandated benefits (for example, insulin pumps for diabetes treatment) is not subject to Benefit Maximums.*

*Nebulizers, including facemasks and tubing, are payable under this DME Benefit.

Orthotic and Prosthetic Devices

Maximum benefit – subject to the same maximums that apply to any other illness

The copayment is equal to the same copayment that applies to any other illness.

Subscriber Eligibility:

All active full-time employees of the Contract Holder who regularly work at least the minimum number of hours per week as defined by the Contract Holder and agreed to by HMO.

Eligible for benefits on the date of hire.

Dependent Eligibility:

A dependent unmarried child of the Subscriber as described in the Eligibility and Enrollment section of the EOC who is:

- i. under 26 years of age; or
- ii. under 26 years of age, dependent on a parent or guardian Member, and attending a recognized college or university, trade or secondary school on a full-time basis; or
- iii. chiefly dependent upon the Subscriber for support and maintenance, and is 19 years of age or older but incapable of self-support due to a physical or mental disability, injury, illness or condition as long as one of the following conditions is met:
 - the physical or mental disability, injury, illness or condition started prior to attaining age 26, or if a student, 26; or
 - the physically or mentally disabled child was covered under the Subscriber's health plan in effect on the day before the effective date of this plan.

The HMO will send a notice to the Subscriber requesting proof of the child's physical or mental disability, injury, illness or condition and must be given to the HMO within 60 days of receiving the notice of proof.

The HMO will make a determination as to whether the dependent child is entitled to be covered under this plan. However, if the HMO fails to make the necessary determination by the effective date of coverage, the child will be covered under this plan pending the determination of eligibility due to the physical or mental disability, injury, illness or condition.

Proof of continued physical or mental disability, injury, illness or condition, including a medical examination, must be submitted to HMO as requested, but not more frequently than annually beginning after the two-year period following the date the child becomes covered under this plan.

**Termination of
Coverage:**

Coverage of the Subscriber and the Subscriber's dependents who are Members, if any, will terminate immediately following the date on which the Subscriber ceased to meet the eligibility requirements.

Coverage of Covered Dependents will cease immediately following the date on which the dependent ceased to meet the eligibility requirements.

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

If your Aetna plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, then until you make this designation, Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

If your Aetna plan allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your Aetna plan provides coverage for obstetric or gynecological care and requires the designation of a primary care provider then you do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

IMPORTANT HEALTH CARE REFORM INFORMATION

Some language changes in response to recent changes to preventive services coverage and women's preventive health coverage under the Federal Affordable Care Act (ACA) may not be included in the enclosed evidence of coverage. This may be because the language is still pending regulatory review and approval. However, please note that Aetna is administering medical and outpatient prescription drug coverage in compliance with the applicable components of the ACA.

The following is a summary of the recent changes to preventive services coverage and women's preventive health coverage under the ACA that applies to non-grandfathered plans that are not otherwise exempt from the requirements. Preventive services, as required by ACA, will be paid without cost-sharing such as payment percentages, copayments and deductibles.

For details on any benefit maximums and the cost-sharing under your plan, call the Member Services number on the back of your ID card.

1. An annual routine physical exam for covered persons through age 21.
2. For covered females:
 - Screening and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
 - Screening and counseling services, such as:
 - Interpersonal and domestic violence;
 - Sexually transmitted diseases; and
 - Human Immune Deficiency Virus (HIV) infections.
 - Screening for gestational diabetes.
 - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older and limited to once every three years.
 - A routine well woman preventive exam office visit, including Pap smears, in accordance with the recommendations by the Health Resources and Services Administration.
3. Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:
 - Preventive counseling visits and/or risk factor reduction intervention;
 - Medical nutrition therapy;
 - Nutritional counseling; and
 - Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

Benefits under your plan may be subject to visit maximums.

4. Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.

Benefits under your plan may be subject to visit maximums.

5. Screening and counseling services to aid you to stop the use of tobacco products. Coverage includes:

- Preventive counseling visits;
- Treatment visits; and
- Class visits.

Benefits under your plan may be subject to visit maximums.

6. Prenatal care received by a pregnant female. Coverage is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).
7. Comprehensive lactation support, (assistance and training in breast-feeding), and counseling services provided by a certified lactation support provider, in a group or individual setting, to females during pregnancy and in the post partum period.

The rental or purchase of breast-feeding durable medical equipment for the purpose of lactation support (pumping and storage of breast milk), and the purchase of the accessories and supplies needed to operate the item. Aetna reserves the right to limit the payment of charges up to the most cost-efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of Aetna.

Benefits under your plan may be subject to maximums.

8. For females with reproductive capacity, coverage includes:

- FDA-approved contraceptive methods including certain FDA-approved generic drugs, implantable devices, sterilization procedures and patient education and counseling for women with reproductive capacity.
- Counseling services provided by a physician in either a group or individual setting on contraceptive methods. Benefits may be subject to visit maximums.
- Female voluntary sterilization procedures and related services and supplies including tubal ligation and sterilization implants. Coverage does not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.
- FDA-approved female generic emergency contraceptive methods that are prescribed by your physician. The prescription must be submitted to the pharmacist for processing.

Additional exemptions may apply to plans that are sponsored by religious employers or religious organizations and meet certain criteria which exempt the health plan from the federal requirement to provide coverage for contraceptive services.

The drug list is subject to change. Visit “Medication Search” on your secure member website at www.aetna.com for the most up-to-date information on drug coverage for your plan.