AETNA HEALTH INC.
(ILLINOIS)

GROUP AGREEMENT COVER SHEET

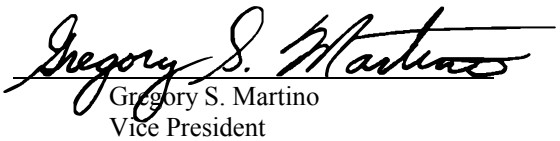
Contract Holder:	The Government of the District of Columbia
Contract Holder Number:	172614 739
HMO Referred Benefit Level:	CITIZEN OPEN ACCESS PLAN Benefits Package
Effective Date:	12:01 a.m. on January 1, 2013
Term of **Group Agreement:**	The **Initial Term** shall be: From January 1, 2013 through December 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 Illinois.

Notice Address for **HMO**:

Employer Services
7400 West Campus Road
New Albany, OH 43054

The signature below is evidence of Aetna Health Inc. 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 Inc.

AETNA HEALTH INC.

By: 
Gregory S. Martino
Vice President

Contract Holder Name: The Government of the District of Columbia
Contract Holder Number: 172614
Contract Holder Locations: 739
Contract Holder Group Agreement Effective Date: January 1, 2013

AETNA HEALTH INC.
(ILLINOIS)

GROUP AGREEMENT

This **Group Agreement** is entered into by and between Aetna Health 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 Inc.

1.3 **"Certificate"** means the Evidence of Coverage issued pursuant to this **Group Agreement**.

1.4 **"Grace Period"** is defined in Section 3.3.

1.5 **"Group Agreement"** means the **Contract Holder's** Group Application, this document, the attached Cover Sheet; the **Certificate** 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 **Certificate**. In the event of a conflict between the terms of this **Group Agreement** and the terms of the **Certificate**, 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 **Certificate** in order to promote orderly and efficient administration.

SECTION 3. PREMIUMS AND FEES

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 3.5 below. **Premiums** are subject to adjustment, if any, for partial month participation as specified in Section 3.4 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 **Fees.** In addition to the **Premium**, **We** may charge the following fees:

- An installation fee may be charged upon initial installation of coverage or any significant change in installation (e.g., a significant change in the number of **Members** or a change in the method of reporting **Member** eligibility to **Us**). A fee may also be charged upon initial installation for any custom plan set-ups.

- A billing fee may be added to each monthly **Premium** bill. The billing fee may include a fee for the recovery of any surcharges for amounts paid through credit card, debit card or other similar means.

- A reinstatement fee as set forth in Section 6.4.

3.3 **Past Due Premiums and Fees.** If a **Premium** payment or any fees are not paid in full by **Contract Holder** on or before the **Premium Due Date**, a late payment charge of 1½% of the total amount due per month (or partial month) will be added to the amount due. If all **Premiums** and fees 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** and fees 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** or fees, including reasonable attorneys' fees and costs of suit.

3.4 **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.

3.5 **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**, provided that no such adjustment will be made during the **Initial Term** except to reflect changes in applicable law or regulation or a judicial decision having a material impact on the cost of providing **Covered Benefits** to **Members**.

3.6 **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 **Certificate**, and are subject to the payment of all applicable **Premiums**.

SECTION 4. ENROLLMENT

4.1 **Open Enrollment.** As described in the **Certificate**, **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 **Certificate**, 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 **Certificate** 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**. **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 **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 it's 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 Insurance 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 **Certificate**, 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. However if a **Provider** terminates participation, **HMO** will notify the **Contract Holder** and **Subscribers** 45 days in advance of such termination, when possible. If **HMO** receives less than 45 days notice from the **Provider**, the **HMO** will immediately inform the **Contract Holder** and **Subscribers** of such termination. If **HMO** terminates a **Provider's** participation, **HMO** will notify the **Contract Holder** and **Subscribers** 60 days in advance of such termination, when possible. If a **Provider's** license is disciplined by a state licensing board, **HMO** may provide immediate notice of termination. **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**, **Certificate** 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 **Certificate** 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 **Certificate** 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 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. 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.

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 INC.
(ILLINOIS)

GROUP AGREEMENT AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The following Sub-section 9.6. Claim Determinations, is hereby substituted for the section of the same name presently appearing under Section 9 MISCELLANEOUS of the **Group Agreement**

9.6 **Claim Determinations**. **We** have responsibility to review all claims for **Covered Benefits** under this **Group Agreement**.

In exercising such responsibility, **We** have the right to:

determine all questions of eligibility of **Members**;

determine the amount and type of benefits payable in accordance with the terms of this **Group Agreement**; and

interpret the provisions of this **Group Agreement**, including, but not limited to, the denial of certification of the medical necessity of hospital or medical treatment.

We have the right to adopt reasonable:

policies;

procedures;

rules; and

interpretations;

of this **Group Agreement** to promote orderly and efficient administration.

Our determinations, interpretations, and decisions on these matters are subject to de novo review by an impartial reviewer as provided in this **Group Agreement** or as allowed by law.

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 claim 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.

AETNA HEALTH INC.
(ILLINOIS)

AMENDMENT TO THE GROUP AGREEMENT
TERMINATION

Contract Holder Group Agreement Effective Date: January 1, 2013

The "Termination" section of the **Group Agreement** is hereby amended to delete section 6.3 entitled "Termination by Us". The following replaces section 6.3:

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 31 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;

- On the **Contract Holder's Renewal Date** upon 90 days prior written notice to **Contract Holder** and **Subscriber,** if **We** cease to offer the product to which the **Group Agreement** relates;

- On the **Contract Holder's Renewal Date** upon 180 days prior written notice to **Contract Holder** and **Subscriber,** 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 Insurance and consistent with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or by applicable federal rules and regulations, as amended; or

- Immediately upon notice to **Contract Holder** if **Contract Holder's** membership in the association ceases.

AETNA HEALTH INC.
(ILLINOIS)

GROUP AGREEMENT AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. **(HMO) Group Agreement** issued to the **Contract Holder** is hereby amended as follows:

Section 5., **RESPONSIBILITIES OF THE CONTRACT HOLDER,** is hereby amended to include the following:

5.7 **The Summary of Benefits and Coverage (SBC) and Notices of Material Modifications, (as required under Federal Law).**

The **Contract Holder** agrees to the following:

Distribution of the Summary of Benefits and Coverage and Notices of Material Modifications
The **Contract Holder** agrees to distribute and deliver to **Our Members,** and prospective **Members,** the *Summary of Benefits and Coverage* and *Notices of Material Modification*, as they apply, in accordance with the:

- delivery;
- timing; and
- trigger;

rules under federal law and regulation.

Certification of Compliance
The **Contract Holder** agrees to certify to **Us** on an annual basis, or upon **Our** request, that the **Contract Holder** has provided and will provide the *Summary of Benefits and Coverage* and *Notices of Material Modification*, as they apply, to **Our Members,** and prospective **Members,** consistent with the delivery, timing and trigger rules under federal law and regulation. The **Contract Holder** agrees to submit such certification related to its responsibilities for distribution of the *Summary of Benefits and Coverage* and *Notices of Material Modification* within 30 calendar days of **Our** request.

The **Contract Holder** shall, upon **Our** request, and within 30 calendar days, submit information or proof to **HMO** related to its responsibilities for the distribution of the *Summary of Benefits and Coverage* and *Notices of Material Modification*, in a form that **We** will accept, that it continues to meet the rules related to the delivery, timing and triggers of the *Summary of Benefits and Coverage* and *Notices of Material Modification* rules, as they apply.

Indemnification: *As relating to the Summary of Benefits and Coverage and Notices of Material Modification; as required under Federal law*

The **Contract Holder** agrees to indemnify and hold **Us** harmless for **Our** liability (as determined by either state or federal regulatory agencies; boards; or other governmental bodies) that was directly caused by the **Contract Holder's**:

- negligence;
- breach of this **Group Agreement**;
- breach of state or federal laws that apply; or
- willful misconduct;

and the act was related to, or arose out of, the **Contract Holder's** obligation and role for the delivery of the *Summary of Benefits and Coverage* and *Notices of Material Modification*, as they apply, to **Our Members,** and prospective **Members,** in accordance with the:

- delivery;
- timing; and
- trigger;

rules under federal law and regulation.

These provisions apply to the **Group Agreement** and any **Service Agreement** that has been issued to the **Contract Holder**.

AETNA HEALTH INC.
(ILLINOIS)

EVIDENCE OF COVERAGE

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

HMO agrees with the **Contract Holder** to provide coverage for benefits, in accordance with the conditions, rights, and privileges as set forth in this **Certificate**. **Members** covered under this **Certificate** are subject to all the conditions and provisions of the **Group Agreement**.

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 **Certificate**.

Certain words have specific meanings when used in this **Certificate**. The defined terms appear in bold type with initial capital letters. The definitions of those terms are found in the Definitions section of this **Certificate**.

This Certificate is not in lieu of insurance for Workers' Compensation. This Certificate is governed by applicable federal law and the laws of Illinois.

READ THIS ENTIRE CERTIFICATE 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 CERTIFICATE.

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

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

THIS CERTIFICATE 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 CERTIFICATE.

PARTICIPATING PROVIDERS, NON-PARTICIPATING PROVIDERS, INSTITUTIONS, FACILITIES OR AGENCIES ARE NEITHER AGENTS NOR EMPLOYEES OF HMO.

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

HMO PROCEDURE

A. **Selecting a Participating Primary Care Physician.**

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 **Certificate**. 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. Until a **PCP** is selected, benefits will be limited to coverage for **Medical Emergency** care.

In addition to a **PCP**, a female **Member** may also select a **Participating Women's Principal Health Care Provider** from the **HMO's** Directory of **Participating Providers** to access **Covered Benefits** as described in this **Certificate**. A female **Member** is not required to select a **Participating Women's Principal Health Care Provider** as outlined in the Covered Benefits section of this **Certificate**.

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** or for certain direct access **Specialist** benefits as described in this **Certificate**, 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 **Certificate**. It is a **Member's** responsibility to consult with the **PCP** in all matters regarding the **Member's** medical care.

A female **Member** does not need a referral from her **PCP** for any medical service that is rendered by her **Participating Women's Principal Health Care Provider** and provided as a **Covered Benefit** under the terms of the **Certificate**. **Participating Women's Principal Health Care Providers** may also refer a female **Member** directly to other **Participating Providers** for **Covered Benefits** without the **Member's** having to go back to her **PCP**. All **HMO** pre-authorization and coordination requirements apply.

Certain **PCP** offices are affiliated with integrated delivery systems or other provider groups (i.e., Independent Practice Associations and Physician-Hospital Organizations), and **Members** who select these **PCPs** will generally be referred to **Specialists** and **Hospitals** within that system or group. However, if the group does not include a **Provider** qualified to meet the **Member's** medical needs, the **Member** may request to have services provided by nonaffiliated **Providers**.

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 the Covered Benefits section of this **Certificate** for details.

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**. 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. The **Member** must then cooperate with **HMO** to select another **PCP**. Until a **PCP** is selected, benefits are limited to coverage for **Medical Emergency** care.

HMO will provide all **Subscribers** with a 60 day advance notice of any **Participating Provider's** termination provided that **HMO** receives such notice from the **Participating Provider**. If **HMO** receives less than a 60 day notice, they will immediately notify **Subscribers** of any termination.

D. **Continuity of Care.**

If a **Member's Provider** terminates participation with **HMO** for reasons other than imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board that impairs the **Provider's** ability to practice, **HMO** will continue coverage for a **Member** to continue an ongoing course of treatment with the **Member's** current **Provider** during a transitional period. That **Provider** shall continue to provide medical services or treatment to the **Member** for up to 90 days from the date of the notice to the **Member** of the **Provider's** termination of participation with **HMO** or if the **Member** has entered the third trimester of pregnancy, for a transitional period that includes the provision of postpartum care directly related to the delivery. The coverage will be authorized by **HMO** for the transitional period only if the **Provider** agrees to accept reimbursement at the rates applicable prior to the start of the transitional period as payment in full, adhere to **HMO's** quality standards and to provide medical information related to such care, and to adhere to **HMO's** policies and procedures. This paragraph shall not be construed to require **HMO** to provide coverage for benefits otherwise not covered under this **Certificate**.

For new **HMO Members**, coverage will be provided to continue an ongoing course of treatment with **Member's** current **Provider**, even if non-participating with **HMO** for a transitional period of up to 90 days from the **Member's Effective Date of Coverage**. If the **Member** has entered the third trimester of pregnancy as of the **Effective Date of Coverage**, the transitional period shall include the provision of postpartum care directly related to the delivery. The coverage will be authorized by **HMO** for the transitional period only if the **Provider** agrees to accept reimbursement at the rates established by **HMO** as payment in full, adhere to **HMO's** quality standards and to provide medical information related to such care, and to adhere to **HMO's** policies and procedures. This paragraph shall not be construed to require **HMO** to provide coverage for benefits otherwise not covered under this **Certificate**.

E. **Changing a PCP.**

A **Member** may change their **PCP** or **Participating Women's Health Care Provider** at any time by calling the Member Services toll-free telephone number listed on the **Member's** identification card 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 upon **HMO's** receipt and approval of the request.

F. **Ongoing Reviews.**

HMO's Medical Director or Designee conducts ongoing reviews of those services and supplies which are recommended or provided by **Health Professionals** to determine whether such services and supplies are **Covered Benefits** under this **Certificate**. If **HMO's Medical Director or Designee** 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 Utilization Review Determination Appeal section of this **Certificate**.

G. **Pre-authorization.**

Certain services and supplies under this **Certificate** may require pre-authorization by **HMO's Medical Director or Designee** to determine if they are **Covered Benefits** under this **Certificate.**

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**;

   b. live or work in the **Service Area;** and

   c. enroll in Medicare Supplementary Medical Insurance (Part B), if eligible for this program.

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 of a **Subscriber** under this **Certificate**; or

   b. 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 in this **Certificate** and on the Schedule of Benefits; and

   c. enrolled in Medicare Supplementary Medical Insurance (Part B), if eligible for this program.

   No individual may be covered both as an employee and dependent and no individual may be covered as a dependent of more than one employee.

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 and you must pay any required **Premium** within the 31 days of enrollment. If coverage does not require the payment of an additional **Premium** for a **Covered Dependent**, the **Subscriber** must still enroll the child within 31days 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 **Certificate**. 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. Handicapped Children.

Coverage is available for a child who is 19 years of age or older but incapable of self-sustaining employment due to mental incapacity or physical handicap and is dependent upon the **Subscriber** or another care provider for lifetime care and supervision. The incapacity must have commenced prior to the age the dependent would have lost eligibility. In order to continue coverage for a handicapped child, the **Subscriber** must provide evidence of the child's incapacity and dependency to **HMO** within 31 days of the date the child's coverage would otherwise terminate. Proof of continued incapacity, including a medical examination, must be submitted to **HMO** as requested, but not more frequently than annually beginning after the 2 year period following the child's attainment of the age specified on the Schedule of Benefits. This eligibility provision will no longer apply on the date the dependent's incapacity 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 **Certificate**, 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's Medical Director or Designee** that a dependent meets the eligibility requirements described in this **Certificate**.

6. Special Enrollment Period.

An eligible individual and eligible dependents may be enrolled during special enrollment periods. 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 requirements a, b, c and d 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**;

b. the eligible individual or eligible dependent declines coverage in writing under **HMO**;

c. the eligible individual or eligible dependent loses coverage under the other group health plan or other health insurance coverage for 1 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.

   iii Loss of eligibility includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing.

   iv 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 **Certificate**; and

d. the eligible individual or eligible dependent enrolls within 31 days of the loss.

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 **Certificate**.

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 dependents enrolling during a special enrollment period will not be subject to late enrollment provisions, if any, described in this **Certificate**.

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 **Certificate**.

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 **Certificate**. To be covered, the **Member** must utilize **Participating Providers** and is subject to all the terms and conditions of this **Certificate**.

D. **Effect of Prior Coverage**.

This provision describes the **HMO's** obligations under the **Group Agreement** if the **HMO** replaces a **Prior Plan**.

An individual who is a eligible for coverage under this **Group Agreement** and who does not satisfy the Hospital Confinement requirement of this **Group Agreement** on its effective date, will be eligible for the special benefit described below if that person is **Totally Disabled** and was validly covered (including any benefits extension provision) under the **Prior Plan** on its date of discontinuance.

The special benefit is the level of benefits provided by this **Group Agreement** reduced by any benefits provided by the **Prior Plan**. The special benefit will cease on the first to occur of:

- the date the individual meets all eligibility requirements of the **HMO**;
- the date coverage would terminate in accordance with the **HMO's** individual termination provisions (e.g. termination of employment, loss of dependent eligibility); or

- the end of any period of extension which is or would have been required of the **Prior Plan** if it were subject to Illinois Insurance Regulation §2013.60 on the date of its discontinuance.

The Extension of Benefits provision of this **Certificate** will not apply to a person when the special benefit ceases.

In the case of any preexisting conditions limitation, if any, included in this **Certificate**, the level of benefits applicable to preexisting conditions during the period of time such limitation applies shall be the lesser of:

- the benefits provided by this **Certificate** without application of the preexisting conditions limitation; and

- the benefits of the **Prior Plan**.

In applying any **Deductibles**, **Copayments**, or waiting periods under this **Certificate**, credit will be given for the satisfaction or partial satisfaction of the same or similar provisions under the **Prior Plan** providing similar benefits.

COVERED BENEFITS

A **Member** shall be entitled to the **Covered Benefits** as specified below, in accordance with the terms and conditions of this **Certificate**. Unless specifically stated otherwise, in order for benefits to be covered, they must be **Medically Necessary**. For the purpose of coverage, **HMO's Medical Director or Designee** may determine with the **Member's PCP** and **Participating Women's Principal Health Care Provider** whether any benefit provided under the **Certificate** 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 CERTIFICATE.

To be **Medically Necessary**, the service or supply must:

- be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the **Member's** overall health condition;

- be care or services related to diagnosis or treatment of an existing illness or injury, except for covered periodic health evaluations and preventive and well baby care, as determined by **HMO's Medical Director or Designee**;

- be a diagnostic procedure, indicated by the health status of the **Member** and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the **Member's** overall health condition;

- include only those services and supplies that cannot be safely and satisfactorily provided at home, in a **Physician's** office, on an outpatient basis, or in any facility other than a **Hospital**, when used in relation to inpatient **Hospital** services; and

- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests.

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.

In the event of a dispute between the **PCP** or a **Participating Provider** and the **HMO** regarding the **Medical Necessity** of a **Covered Benefit** proposed by either the **PCP** or a **Participating Provider**, the **Member** (or the **Member's** next of kin or legal representative if the **Member** cannot act for himself or herself) together with the **Member's PCP** or the **Participating Provider** and the **HMO** shall select an independent **Physician** of the same class of license as the **PCP** or **Participating Provider**, but who is not affiliated with the **HMO**, to review whether or not the proposed **Covered Benefit** is **Medically Necessary**. If in the opinion of the independent **Physician** the proposed **Covered Benefit** is **Medically Necessary**, the **HMO** shall provide the **Covered Benefit**. Any services rendered to treat the **Member's** condition will not be covered if:

- The **PCP** or **Participating Physician** does not request a review in accordance with this provision; or
- The opinion of the independent **Physician** is that the proposed **Covered Benefit** is not **Medically Necessary**.

Until an agreement is reached that such services will be **Covered Benefit**, such services will be excluded from coverage. The exclusion of coverage in such cases is solely a benefit determination and not a medical treatment determination or recommendation. The **Member** and the **PCP** or **Participating Provider** may elect to proceed with the planned treatment, at the **Member's** expense, and appeal the denial of a claim for such services in accordance with the **HMO's** Utilization Review Determination Appeal section.

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

If a **Member** has questions regarding coverage under this **Certificate**, the **Member** may call the Member Services toll-free telephone number listed on the **Member's** identification card.

THE MEMBER IS RESPONSIBLE FOR PAYMENT OF THE APPLICABLE DEDUCTIBLE AND 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 CERTIFICATE, 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;

   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 **Certificate**.

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;

   b. routine physical examinations;

   c. routine gynecological examinations, including Pap smears, 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 **Certificate** for a description of these benefits;

   d. routine hearing screenings;

   e. immunizations (but not if solely for the purpose of travel or employment);

   f. routine vision screenings.

   g. annual digital rectal exam for all covered males age 40 and over.

6. Injections, including allergy desensitization injections.

7. Casts and dressings.

8. Health Education Counseling and Information.

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's Medical Director or Designee** to a **Participating Provider**.

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

   - age 35 to 39, one baseline mammogram;
   - age 40 and older, 1 routine mammogram every year; or
   - when Medically Necessary.

3. One Prostate Specific Antigen (PSA) blood test per calendar year for covered males age 40 and older.

4. One colorectal cancer screening with sigmoidoscopy or fecal occult blood testing every three years for **Members** age 50 and older, and for **Members** who may be classified as high risk age 30 and older.

C. **Specialist Physician Benefits.**

Covered Benefits include outpatient and inpatient services.

Member may request a second opinion regarding a proposed surgery or course of treatment recommended by **Member's PCP** or a **Specialist**. Second opinions must be obtained by a **Participating Provider** and are subject to pre-authorization. To request a second opinion, **Member** should contact their **PCP** for a **Referral**.

If a **Member** requires ongoing care from a **Specialist**, the **Member** may receive a standing **Referral** to such **Specialist**. If **PCP** in consultation with a **HMO** Medical Director and an appropriate **Specialist** determines that a standing **Referral** is warranted, the **PCP** shall make the **Referral** to a **Specialist**. This standing **Referral** shall be pursuant to a treatment plan approved by the **HMO** Medical Director in consultation with the **Member**, the **Member's PCP** and **Specialist**.

D. **Direct Access Specialist Benefits.**

The following services are covered without a **Referral** when rendered by a **Participating Provider**.

- Routine Gynecological Examination(s). Routine gynecological visit(s) and Pap smear(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. See the **Infertility** Services section of this **Certificate** for a description of covered **Infertility** services.
- Routine Eye Examinations, including refraction, as follows:

  1. if **Member** is age 1 through 18 and wears eyeglasses or contact lenses, 1 exam(s) every 12-month period.
  2. if **Member** is age 19 and over and wears eyeglasses or contact lenses, 1 exam(s) every 24-month period.
  3. if **Member** is age 1 through 45 and does not wear eyeglasses or contact lenses, 1 exam(s) every 36-month period.

4. if **Member** is age 46 and over and does not wear eyeglasses or contact lenses, 1 exam(s) every 24-month period.

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

Outpatient and inpatient prenatal and postpartum care and obstetrical services provided by **Participating Providers** are a **Covered Benefit**. The **Participating Provider** is responsible for obtaining any required pre-authorizations for all non-routine obstetrical services from **HMO's Medical Director or Designee** after the first prenatal visit. Except to the extent of any applicable **Deductibles, Copayments** or coinsurance the **Member** will not be held liable for **Covered Benefits** for which the **Participating Provider** has not received prior authorization from **HMO's Medical Director or Designee**.

Coverage includes prenatal HIV testing ordered by a **Participating Physician** or by a **Participating Health Professional** who has a written agreement with a **Participating Physician** which authorizes these services.

Coverage does not include routine maternity care (including delivery) received while outside the **Service Area** unless the **Member** receives pre-authorization from **HMO's Medical Director or Designee**, or is outside the **Service Area** due to circumstances beyond her control. As with any other medical condition, **Emergency Services** are covered when **Medically Necessary**.

As an exception to the **Medically Necessary** requirements of this **Certificate**, 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 1 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 & Skilled Nursing Facility Benefits.**

A **Member** is covered for services only at **Participating Hospitals** and **Participating Skilled Nursing Facilities**. All services are subject to pre-authorization by **HMO's Medical Director or Designee**. 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.

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

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**.

G. **Transplants Benefits.**

Covered transplants must be ordered by the **Member's PCP** and **Participating Specialist Physician** and pre-authorized by **HMO's Medical Director or Designee**. The transplant must be performed at **Hospitals** specifically approved and designated by **HMO** to perform these procedures. Coverage for a transplant where a **Member** is the recipient includes coverage for the medical and surgical expenses of a live donor, to the extent these services are not covered by another plan or program.

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's Medical Director or Designee**.

I. **Substance Abuse Benefits.**

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

1. 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. Group outpatient care visits may be substituted on a two-for-one basis for individual outpatient care visits as deemed appropriate by the **Member's PCP.**

   Outpatient benefit exchanges are a **Covered Benefit**. When authorized by **HMO's Medical Director or Designee**, services in a day **Hospital**, residential **Hospital** or non-hospital or intensive outpatient services may be may be exchanged on a two-for-one basis for inpatient **Rehabilitation.** Requests for a benefit exchange must be initiated by the **Member's Participating Behavioral Health Provider** under the guidelines set forth by the **HMO's Medical Director or Designee**. **Member** must utilize all outpatient **Substance Abuse** benefits available under the **Certificate** and pay all applicable **Deductibles** and **Copayments** before an inpatient and outpatient visit exchange will be considered. The **Member's Participating Behavioral Health Provider** must demonstrate **Medical Necessity** for extended visits and be able to support the need for hospitalization if additional visits were not offered. Request for exchange must be approved in writing by **HMO's Medical Director or Designee** prior to utilization.

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

J. **Mental Health Benefits.**

A **Member** is covered for services for the treatment of the following **Mental or Behavioral Conditions** through **Participating Behavioral Health Providers**.

1. Outpatient benefits are covered for short-term, outpatient evaluative and crisis intervention or home health mental health services, and are subject to the maximum number of visits, if any, shown on the Schedule of Benefits. Group outpatient care visits may be substituted on a two-for-one basis for individual outpatient care visits as deemed appropriate by the **Member's PCP.**

2. Inpatient benefits may be covered for medical, nursing, counseling or therapeutic services in an inpatient, **Hospital** or non-hospital residential facility, appropriately licensed by the Department of Health or its equivalent. Coverage, if applicable, is subject to the maximum number of days, if any, shown on the Schedule of Benefits.

3. Inpatient benefit exchanges are a **Covered Benefit**. When authorized by **HMO**, 1 mental health inpatient day, if any, may be exchanged for up to 4 outpatient or home health visits. This is limited to an exchange of up to a maximum of 10 inpatient days for a maximum of 40 additional outpatient visits. One inpatient day, if any, may be exchanged for 2 days of treatment in a **Partial Hospitalization** and/or outpatient electroshock therapy (ECT) program in lieu of hospitalization up to the maximum benefit limitation upon approval by **HMO**.

   Requests for a benefit exchange must be initiated by the **Member's Participating Behavioral Health Provider** under the guidelines set forth by the **HMO's Medical Director or Designee**. **Member** must utilize all outpatient mental health benefits, if any, available under the **Certificate** and pay all applicable **Deductibles** and **Copayments** before an inpatient and outpatient visit exchange will be considered. The **Member's Participating Behavioral Health Provider** must demonstrate **Medical Necessity** for extended visits and be able to support the need for hospitalization if additional visits were not offered. Request for exchange must be pre-authorized by **HMO's Medical Director or Designee**.

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

1. **Emergency Care:**

   A **Member** is covered for **Emergency Services**, provided the service is a **Covered Benefit**, and **HMO's Medical Director or Designee's** review determines that a **Medical Emergency** existed at the time medical attention was sought by the **Member**.

   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**. In connection with use of an ambulance for a **Medical Emergency**, the determination that a **Medical Emergency** existed may be made by any attending **Provider** (public safety official or emergency medical personnel).

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 Primary Care Physician.** If the **Member's Primary Care Physician** 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** 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 services received.

L. **Outpatient Rehabilitation Benefits.**

The following benefits are covered by **Participating Providers** upon **Referral** issued by the **Member's PCP** and pre-authorization by **HMO's Medical Director or Designee**.

1. A limited course of cardiac rehabilitation following an inpatient **Hospital** stay is covered when **Medically Necessary** following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.

2. Pulmonary rehabilitation following an inpatient **Hospital** stay is covered when **Medically Necessary** for the treatment of reversible pulmonary disease states.

3. Cognitive therapy associated with physical rehabilitation is covered for non-chronic conditions and acute illnesses and injuries as part of a treatment plan coordinated with **HMO's Medical Director or Designee**. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.

4. Physical therapy is covered for non-chronic conditions and acute illnesses and injuries. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.

5. Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute illnesses. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.

6. Speech therapy is covered for non-chronic conditions and acute illnesses and injuries and is subject to the limits, if any, shown on the Schedule of Benefits. Services rendered for the treatment of delays in speech development, unless resulting from disease, injury, or congenital defects, are not covered.

M. **Home Health Benefits.**

The following services are covered when rendered by a **Participating** home health care agency. Pre-authorization must be obtained from the **Member's** attending **Participating Physician**. **HMO** shall not be required to provide home health benefits when **HMO's Medical Director or Designee** determines the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide appropriate care.

1. Skilled nursing services for a **Homebound Member**. Treatment must be provided by or supervised by a registered nurse.

2. Services of a home health aide. These services are covered only when the purpose of the treatment is **Skilled Care**.

3. Medical social services. Treatment must be provided by or supervised by a qualified medical **Physician** or social worker, along with other **Home Health Services**. The **PCP** must certify that such services are necessary for the treatment of the **Member's** medical condition.

4. Short-term physical, speech, or occupational therapy is covered. Coverage is limited to those conditions and services under the Outpatient Rehabilitation Benefits section of this **Certificate**.

Coverage is subject to the maximum number of visits, if any, shown on the Schedule of Benefits.

N. **Hospice Benefits.**

Hospice Care services for a terminally ill **Member** are covered when pre-authorized by **HMO's Medical Director or Designee**. 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 and emotional support; and other home health benefits listed in the Home Health Benefits section of this **Certificate**.

Coverage is not provided for bereavement counseling, funeral arrangements, pastoral counseling, and financial or legal counseling. 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. Coverage is not provided for **Respite Care**.

O. **Prosthetic Appliances Benefits.**

The **Member's** initial provision and replacement of a prosthetic device 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's Medical Director or Designee**. 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 **Certificate**. **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.**

Injectable medications, including those medications intended to be self administered, are a **Covered Benefit** when an oral alternative drug is not available, unless specifically excluded as described in the Exclusions and Limitations section of this **Certificate**. Medications must be prescribed by a **Provider** licensed to prescribe federal legend prescription drugs or medicines, and pre-authorized by **HMO's Medical Director or Designee**. 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.

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 1 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 1 study published in a nationally recognized peer reviewed journal.

Q. **Reconstructive Breast Surgery Benefits.**

Reconstructive breast surgery resulting from a mastectomy is covered. Coverage includes reconstruction of the breast on which the mastectomy is performed including areolar reconstruction and the insertion of a breast implant; surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed; and **Medically Necessary** physical therapy to treat the complications of mastectomy, including lymphedema.

As an exception to the **Medically Necessary** requirements of this **Certificate**, the following coverage is provided following a mastectomy for a length of time determined by the attending **Physician** to be **Medically Necessary**. Coverage will include one post-discharge in-home nurse visit or **Physician** office visit, by a licensed **Provider**, to verify the condition of the **Member** in the first 48 hours after discharge.

R. **Comprehensive Infertility Services.**

Infertility services and supplies to diagnose the underlying medical cause of **Infertility** are covered. Coverage is provided for the following outpatient services and supplies:

- In-vitro fertilization;
- Uterine embryo lavage;
- Embryo transfer;
- Artificial Insemination;
- Gamete intrafallopian tube transfer;
- Zygote intrafallopian tube transfer; and
- Low tubal ovum transfer.

Limitations

Covered Benefits will only include charges for procedures for in vitro fertilization, gamete intrafallopian tube transfers and zygote intrafallopian tube transfer if:

- The **Member** has been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate **Infertility** treatments for which coverage is available under this Certificate.

- The **Member** has not undergone 4 completed oocyte retrievals, except that if a live birth follows a completed oocyte retrieval, then 2 more completed oocyte retrievals shall be covered.

- The procedures are performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

S. **Subluxation Benefits**.

Services by a **Participating Provider** when **Medically Necessary** and upon prior **Referral** issued by the **PCP** 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 **Deductible**, 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 **Certificate**.

T. **Additional Benefits.**

- **Diabetic Supplies and Equipment.**

  Equipment, supplies, regular foot care exams, and education services for the treatment of type 1 diabetes, type 2 diabetes, and gestational diabetes mellitus are covered when **Medically Necessary** and when prescribed or ordered by a the **Member's PCP.**

  Coverage also includes diabetic outpatient self-management training and medical nutrition education and shall be limited to the following: (1) 3 **Medically Necessary** visits to a **Provider** upon initial diagnosis of diabetes by the **Member's PCP**; and (2) 2 **Medically Necessary** visits to a **Provider** upon a determination by the **Member's PCP** that a significant change in the **Member's** symptoms or medical condition has occurred. A "significant change" in condition means symptomatic hyperglycemia (greater than 250 mg/dl on repeated occasions), severe hypoglycemia (requiring the assistance of another person), onset of progression of diabetes, or a significant change in the medical condition that would require a significantly different treatment regimen.

- **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 **Certificate**. **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's Medical Director or Designee**.

  Instruction and appropriate services required for the **Member** to properly use the item, such as attachment or insertion, is also covered upon pre-authorization by **HMO's Medical Director or Designee**. 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 **Deductible**, 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 **Certificate**.

EXCLUSIONS AND LIMITATIONS

A. **Exclusions.**

The following are not **Covered Benefits** except as described in the Covered Benefits section of this **Certificate** or by rider(s) and/or amendment(s) attached to this **Certificate**:

- Ambulance services, for routine transportation to receive outpatient or inpatient services.

- Beam neurologic testing.

- Biofeedback, except as pre-authorized by **HMO's Medical Director or Designee**.

- Blood and blood plasma, including but not limited to, provision of blood, blood plasma, blood derivatives, synthetic blood or blood products other than blood derived clotting factors, the collection or storage of blood plasma, the cost of receiving the services of professional blood donors, apheresis or plasmapheresis. Only administration, processing of blood, processing fees, and fees related to autologous blood donations are covered.

- Care for conditions that state or local laws require to be treated in a public facility, including but not limited to, mental illness commitments.

- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.

- **Cosmetic Surgery**, or treatment relating to the consequences of, or as a result of, **Cosmetic Surgery**, other than **Medically Necessary Services**. This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty, except when determined to be **Medically Necessary** by an **HMO Medical Director or Designee**, is not covered. This exclusion does not apply to surgery to correct the results of injuries causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.

- Costs for services resulting from the commission of, or attempt to commit a felony by the **Member**.

- Court ordered services, or those required by court order as a condition of parole or probation.

- **Custodial Care**.

- 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 include removal of bony impacted teeth, bone fractures, removal of tumors, and orthodontogenic cysts.

- Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, 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.

- **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's Medical Director or Designee**, unless pre-authorized by **HMO's Medical Director or Designee**.

  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's Medical Director or Designee** 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 waterbeds, 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 made to vehicles.
- Hypnotherapy, except when pre-authorized by **HMO's Medical Director or Designee**.
- Implantable drugs.
- **Infertility** services not explicitly covered, as provided in the Covered Benefits section of this **Certificate**. This exclusion includes, but is not limited to:

  1. Services for couples in which one of the partners has had a previous sterilization procedure, with or without reversal;

  2. The purchase of donor sperm and any charges for the storage of sperm;

  3. The purchase of donor eggs and fees for an egg donor. An egg donor is a female who has been medically screened, is the designated donor and determined to be compatible for a specific couple or woman;

  4. Any charges associated with care of the donor required for gestational carriers;

  5. Charges associated with cryopreservation or storage of cryopreserved embryos (e.g., office, **Hospital**, ultrasounds, laboratory tests, etc.);

  6. Artificial Insemination for females without male partners attempting to become pregnant who have not had at least 12 cycles of donor insemination (6 cycles for **Members** age 35 or older) prior to enrolling in **HMO's Infertility** program;

  7. Any service provided by a non-participating **Provider** or, in the case of Comprehensive **Infertility** Services, without a prior **Referral** or claim authorization from **HMO's Infertility** program case management unit;

  8. Home ovulation prediction kits;

  9. Drugs related to the treatment of non-covered benefits or related to the treatment of **Infertility** that are not **Medically Necessary**;

10. Fees associated with donor egg programs, including but not limited to fees for laboratory tests and screening costs for potential egg donors, as well as the payment to the donor;

11. Reversal of sterilization surgery; and

12. **Infertility** services performed while the female **Member** is confined in a **Hospital** or any other facility as an inpatient.

- Military service related diseases, disabilities or injuries for which the **Member** is legally entitled to receive treatment at government facilities and which facilities are reasonably available to the **Member**.

- 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's Medical Director or Designee**, 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.

  Determination by **HMO's Medical Director or Designee** shall be made in a timely manner and prior to services being rendered.

- Orthotics.

- Outpatient supplies, including but not limited to, medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings, and reagent strips.

- Payment for that portion of the benefit for which Medicare or another party is the primary payer.

- 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 on an inpatient basis.

- Private duty or special nursing care, unless pre-authorized by **HMO's Medical Director or Designee**.

- Recreational, educational, and sleep therapy, including any related diagnostic testing.

- 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 which a **Member** is not legally obligated to pay in the absence of this coverage.

- 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 **Certificate**.

- 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.

- Services which are not a **Covered Benefit** under this **Certificate**, even when a prior **Referral** has been issued by a **PCP**.

- Specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.

- Specific injectable drugs, including:

    1. experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the Food and Drug Administration (FDA) and the National Institutes of Health (NIH);

    2. needles, syringes and other injectable aids;

    3. drugs related to the treatment of non-covered services; and

    4. drugs related to contraception and performance enhancing steroids.

    This exclusion does not apply to injectable drugs for the treatment of the condition of **Infertility**.

- 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's Medical Director or Designee**.

- Therapy or rehabilitation, 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.

- 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.

- Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded **Members** in accordance with the benefits provided in the Covered Benefits section of this **Certificate**.

- 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 results 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.

- Unauthorized services, including any service obtained by or on behalf of a **Member** without a **Referral** issued by the **Member's PCP** or pre-authorized by **HMO's Medical Director or Designee**. This exclusion does not apply in a **Medical Emergency**, in an **Urgent Care** situation, or when it is a direct access benefit.

- 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.

- Weight reduction programs, or dietary supplements**.**

- Acupuncture and acupuncture therapy, except when performed by a **Participating Physician** as a form of anesthesia in connection with covered surgery.

- Family planning services.

- Temporomandibular joint disorder treatment (TMJ), including but not limited to, treatment performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutics services related to TMJ.

B. **Limitations**.

- In the event there are 2 or more alternative **Medical Services** which in the judgment of **HMO's Medical Director or Designee** with the **Member's PCP or Participating Women's Principal Health Care Provider** are equivalent in quality of care, **HMO** reserves the right to provide coverage only for the least costly **Medical Service**, as determined by **HMO's Medical Director**

or Designee, provided that **HMO's Medical Director or Designee** pre-authorizes the **Medical Service** or treatment.

- Determinations regarding eligibility for benefits, coverage for services, benefit denials and all other terms of this **Certificate** are at the sole discretion of **HMO's Medical Director or Designee,** subject to the terms of this **Certificate** and subject to the laws and regulations of the State of Illinois.

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 **Certificate** will terminate upon the earliest of any of the conditions listed below and termination will be effective on the date indicated on the Schedule of Benefits.

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;

3. the **Subscriber** is no longer eligible as outlined in this **Certificate** and/or 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 **Certificate**.

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 this **Certificate** and/or on the Schedule of Benefits;

2. the **Group Agreement** terminates; or

3. the **Subscriber's** coverage terminates.

Coverage of a dependent will not terminate if the **Subscriber** becomes enrolled under a group Medicare + Choice plan offered by **HMO** or one of its affiliates. However, the dependent's coverage will terminate if the **Subscriber's** coverage terminates under the Medicare + Choice plan.

C. **Termination For Cause.**

HMO may terminate coverage for cause:

1. upon 31 days advance written notice, if the **Member** is unable to establish or maintain, after repeated attempts, a satisfactory physician-patient relationship with a **Participating Provider**. Upon the effective date of such termination, prepayments received by **HMO** on account of such terminated **Member** or **Members** for periods after the effective date of termination shall be re-funded to the **Contract Holder**.

2. upon 31 days advance written notice, if the **Member** has failed to make any required **Deductible** or **Copayment** or any other payment which the **Member** is obligated to pay. Upon the effective date of such termination, prepayments received by **HMO** on account of such terminated **Member** or **Members** for periods after the effective date of termination shall be refunded to **Contract Holder**.

3. upon 31 days advance written notice, if the **Member** refuses to cooperate and provide any facts necessary for **HMO** to administer the **Coordination of Benefits** provisions set forth in this **Certificate**.

4. upon 31 days advance written notice, if the **Member** refuses to cooperate with **HMO** as required by the **Group Agreement**.

5. immediately, upon discovery of a material misrepresentation by the **Member** in applying for or obtaining coverage or benefits under this **Certificate** or upon discovery of the **Member's** commission of 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. **HMO** may, at its discretion, rescind a **Member's** coverage on and after the date that such misrepresentation or fraud occurred. It may also recover from the **Member** the reasonable and recognized charges for **Covered Benefits**, plus **HMO's** cost of recovering those charges, including reasonable attorneys' fees. In the absence of fraud or material misrepresentation, all statements made by any **Member** or any person applying for coverage under this **Certificate** 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.

6. immediately, if a **Member** acts in such a disruptive manner as to prevent or adversely affect the ordinary operations of **HMO** or a **Participating Provider**.

A **Member** may request that **HMO** conduct a grievance hearing, as described in the Administrative Complaints section of this **Certificate**, within 15 working days after receiving notice that **HMO** has or will terminate the **Member's** coverage as described in the Termination For Cause subsection of this **Certificate**. **HMO** will continue the **Member's** coverage in force until a final decision on the grievance is rendered, provided the **Premium** is paid throughout the period prior to the issuance of that final decision. **HMO** may rescind coverage, to the date coverage would have terminated had the **Member** not requested a grievance hearing, if the final decision is in favor of **HMO**. If coverage is rescinded, **HMO** will refund any **Premiums** paid for that period after the termination date, minus the cost of **Covered Benefits** provided to a **Member** during this period.

Coverage will not be terminated on the basis of a **Member's** health status or health care needs, nor if a **Member** has exercised the **Member's** rights under the **Certificate's** Administrative Complaints to register a complaint against **HMO**. The grievance process described in the preceding paragraph applies only to those terminations affected pursuant to the Termination For Cause subsection of this **Certificate**.

HMO shall have no liability or responsibility under this **Certificate** for services provided on or after 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 continue the **Members'** coverage beyond the date coverage terminates.

CONTINUATION AND CONVERSION

A. **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 **Certificate** 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 more than 20 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 **Certificate** 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 **Certificate**:

   The **Member** may elect to continue coverage for 36 months after eligibility for coverage under this **Certificate** 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 has 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 45 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.

B. **Continuation of Coverage - State of Illinois.**

1. **Eligibility:**

In the event of termination of employment or membership, **Members** who have been continuously enrolled under **HMO** for 3 months prior to termination**,** are entitled to continue coverage. Upon termination, the **Contract Holder** will send the **Member** written notice of the availability of continuation. Continuation will not be available to any **Member** if termination of employment is the result of commission of a felony or theft in connection with the **Member's** work and the **Member** admits to or is convicted of such felony or theft.

2. **Enrolling for Continuation:**

A **Member** must request continuation, in writing, within the 10 day period following the later of (a) the date of termination or (b) the date the **Member** is given written notice of the right to continuation by the **Contract Holder**. In no event shall the **Member** elect continuation more than 60 days after the date of termination.

3. **Contributions:**

A **Member** electing continuation must pay to the **Contract Holder**, on a monthly basis in advance, the total amount of **Premium** due. This amount will not be more than the **Contract Holder** rate (subject to any increases the **Contract Holder** may receive).

4. **Coverage Provided:**

If coverage is continued under this section, the **Member** will continue to be covered under this **Group Agreement**. The continued coverage is subject to the conditions, limitations and exclusions of the **Group Agreement**. The **HMO** will not issue a new **Certificate** to continuing **Members**. The **HMO** and the **Contract Holder** may agree to change the **Group Agreement** after the **Member** enrolls for continued coverage and the continuing **Member's** coverage will be subject to such changes.

5. **Duration and Termination of Continuation of Coverage:**

Coverage for a **Member** will cease on the first to occur of:

- The end of the 9 month period which starts on the date coverage would otherwise stop;
- The date the **Member** becomes eligible for Medicare;
- The date the **Member** becomes covered by any other Group medical plan;
- The date the **Member** fails to make the contributions needed;
- The date coverage discontinues as to employees of **Contract Holder;** or
- The date coverage would otherwise terminate as set forth elsewhere in this **Certificate**.

Coverage for a **Covered Dependent** will stop earlier when the person:

- Ceases to be a eligible as a **Covered Dependent**;
- Becomes eligible for other coverage under the **Group Agreement**; or
- The date coverage would otherwise terminate as set forth elsewhere in this **Certificate**.

6. **Conversion:**

If any coverage being continued under this section terminates because the end of the maximum period of continuation has been reached, conversion of coverage will be available at the end of such period on the same terms as those set forth in the "Conversion" section below.

C. **Extension of Benefits Upon Total Disability.**

Any **Member** who is **Totally Disabled** on the date coverage under this **Certificate** terminates is covered in accordance with the **Certificate**.

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's Medical Director or Designee**; 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. 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.

D. **Conversion Privilege.**

This subsection 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; however, in the event continuation coverage ceases pursuant to expiration of COBRA benefits as described in the COBRA Continuation Coverage section of this **Certificate**, 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 **Certificate** and has been continuously enrolled for 3 months under **HMO**, such person may, within 31 days after termination of coverage under this **Certificate**, 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 **Certificate** terminated for 1 of the following reasons:

a. coverage under this **Certificate** 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 this **Certificate** and on the Schedule of Benefits, in which case the **Subscriber** and **Subscriber's** dependents who are **Members** pursuant to this **Certificate**, if any, are eligible to convert;

c. a **Covered Dependent** ceased to meet the eligibility requirements as described in this **Certificate** and on the Schedule of Benefits because of the **Member's** age or the death or divorce of **Subscriber**; or

d. continuation coverage ceased under the COBRA Continuation Coverage section of this **Certificate**.

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.

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 on the Schedule of Benefits or upon death of the **Subscriber** (subject to the ability of minors to be bound by contract).

UTILIZATION REVIEW DETERMINATION APPEAL

For the purposes of this section, "adverse determination" means a determination made by **HMO** that a health care service is not **Medically Necessary**.

A. A **Member** may submit to **HMO** a written, or oral, request to appeal an adverse determination that relates to:

1. health care services, including but not limited to, procedures or treatment, for a **Member** with an ongoing course of treatment ordered by a **Provider**, the denial of which could significantly increase the risk to a **Member's** health; or

2. a treatment **Referral**, service, procedure, or other health care service the denial of which could significantly increase the risk to a **Member's** health.

HMO shall notify the **Member**, or the individual acting on behalf of the **Member**, of it's decision within 24 hours of receipt of all information necessary to conduct an appeal.

A **Member** may also submit to **HMO** a written, or oral, request to appeal an adverse determination that relates to health care services not listed under section A. above.

Under this appeal, **HMO** shall notify the **Member**, or the individual acting on behalf of the **Member**, of it's decision within 15 business days of receipt of all information necessary to conduct an appeal.

B. A **Member** may request an external independent review if the outcome of the appeal filed under section A. above is to uphold the adverse determination for a reason including, but not limited to:

1. the service, procedure, or treatment is not considered **Medically Necessary**;

2. denial of specific tests or procedures;

3. denial of **Referral** to **Specialist Physicians**; or

4. denial of hospitalization requests or length of stay requests.

EXTERNAL INDEPENDENT REVIEW

A **Member**, or an individual acting on behalf of the **Member**, must request an external independent review of adverse determinations, as listed under section B. of the Utilization Review Determination Appeal section of this **Certificate**, in writing within 30 days of receipt of notification by **HMO** to uphold the adverse determination. The request for external independent review should also contain supporting documentation of the **Member's** request for covered services.

Within 30 days after **HMO** receives a request, **HMO** shall: 1) provide a mechanism for joint selection of an external independent reviewer by the **Member**, the **Member's Physician** or other **Provider**, and **HMO**; and 2) forward to the independent reviewer all medical records and supporting documentation pertaining to the service or treatment at issue, a summary description of the area at issue including a statement of **HMO's** decision, the criteria used, and the medical and clinical reasons for that decision.

Within 5 days after the independent reviewer receives all necessary information, they shall review the case and render their decision that is based on whether or not the service or treatment is medically appropriate. The decision by the independent reviewer is final.

ADMINISTRATIVE COMPLAINTS

IF YOU WISH TO DISPUTE A MATTER PERTAINING TO THE **MEDICAL NECESSITY** OF A PROPOSED OR PROVIDED HEALTH CARE SERVICE OR TREATMENT, FOLLOW THE UTILIZATION REVIEW DETERMINATION APPEAL AND EXTERNAL INDEPENDENT REVIEW PROCEDURES OUTLINED IN THIS **CERTIFICATE**.

A **Member** may file an administrative informal complaint, grievance, and grievance appeal in writing, in person, or via the telephone or electronic communication. **Members** are encouraged to call or write **HMO's** Member Services Department if they would like to request administrative service or to express an opinion or file a grievance regarding matters pertaining to the contractual relationship between the **Member** and **HMO**; matters pertaining to the contractual relationship between the **Contract Holder** and **HMO**; or claims payment. At each level of the process, **Members** should be as specific as possible as to the **Member's** desired outcome.

If the **Member** is not satisfied by **HMO's** resolution of any complaint, grievance or grievance appeal, the **Member** may appeal **HMO's** decision to the Illinois Department of Insurance.

COORDINATION OF BENEFITS

Some **Members** have health coverage in addition to the coverage provided under this **Certificate**. When this is the case, the benefits paid by other plans will be taken into account. This may mean a reduction in benefits payable under this **Certificate**, including any applicable benefits payable for dental or pharmacy services or supplies.

When coverage under this **Certificate** and coverage under another plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

A. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

B. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

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. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:

   1. secondary to the plan covering the person as a dependent; and

   2. primary to the plan covering the person as other than a dependent;

   the benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:

   1. covers the person as other than a dependent; and

   2. is secondary to Medicare.

E. Except in the case of a dependent child whose parents are divorced or separated, the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

   If the other plan does not have the rule described in this provision (E) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

F. In the case of a dependent child whose parents are divorced or separated:

1. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (E) above will apply.

2. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

3. If there is not such a court decree:
If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

G. If A, B, C, D, E and F above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:
The benefits of a plan which covers the person as a:

1. laid-off or retired employee; or

2. the dependent of such person;

shall be determined after the benefits of any other plan which covers such person as:

1. an employee who is not laid-off or retired; or

2. a dependent of such person.

If the other plan does not have a provision:

1. regarding laid-off or retired employees; and

2. as a result, each plan determines its benefits after the other,

then the above paragraph will not apply.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:

1. regarding right of continuation pursuant to federal or state law; and

2. as a result, each plan determines its benefits after the other,

then the above paragraph will not apply.

H. 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.

HMO has the right to release or obtain any information and make or recover any payment it considers necessary in order to administer this provision.

Other plan means any other plan of health expense coverage under:

1. Group insurance.

2. Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.

3. No-fault and traditional "fault" auto insurance including medical payments coverage provided on other than a group basis to the extent allowed by law.

Payment of Benefits.
The combined benefits paid will not be more than the expenses recognized under the plans. In a calendar year, **HMO** will pay its regular benefits in full, or a reduced benefit. The reduced amount will be 100% of **Allowable Expenses** less the benefits payable by the other plans. If the plan provides benefits in the form of services rather than cash payment, the cash value will be used. When this provision operates to reduce the total amount of benefits otherwise payable as to a **Member** covered under this **Certificate** during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this coverage.

Facility of Payment.
A payment made by another plan may include an amount which should have been paid under this **Certificate**. If it does, **HMO** may pay that amount to the plan that made that payment. That amount will then be treated as though it were a benefit paid by **HMO**. **HMO** will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Recovery of Overpayments.
If the benefits paid under this **Certificate**, plus the benefits paid by other plans, exceeds the total amount of **Allowable Expenses**, **HMO** has the right to recover the amount of that excess payment if it is the secondary plan, from among 1 or more of the following: (1) any person to or for whom such payments were made; (2) other plans; or (3) any other entity to which such payments were made. This right of recovery shall be exercised at **HMO's** discretion. A **Member** shall execute any documents and cooperate with **HMO** to secure its right to recover such overpayments, upon request from **HMO**.

Medicare And Other Federal Or State Government Programs.
The provisions of this section will apply to the maximum extent permitted by federal or state law. **HMO** will not reduce the benefits due any **Member** due to that **Member's** eligibility for Medicare where federal law requires that **HMO** determine its benefits for that **Member** without regard to the benefits available under Medicare.

The coverage under this **Certificate** is not intended to duplicate any benefits for which **Members** are, or could be, eligible for under Medicare or any other federal or state government programs (such as Workers' Compensation). All sums payable under such programs for services provided pursuant to this **Certificate** shall be payable to and retained by **HMO**. Each **Member** shall complete and submit to **HMO** such consents, releases, assignments and other documents as may be requested by **HMO** in order to obtain or assure reimbursement under Medicare or any other government programs for which **Members** are eligible.

A **Member** is eligible for Medicare any time the **Member** is covered under it. **Members** are considered to be eligible for Medicare or other government programs if they:

1. Are covered under a program;

2. Have refused to be covered under a program for which they are eligible;

3. Have terminated coverage under a program; or

4. Have failed to make proper request for coverage under a program.

Active Employees and Their Dependents Who Are Eligible For Medicare.
Certain rules apply to active employees and their **Covered Dependents** who are eligible for Medicare. When an active **Subscriber,** or the **Covered Dependent** of an active **Subscriber**, is eligible for Medicare and the **Subscriber** or **Covered Dependent** belongs to a group covered by this **Certificate** with 20 or more employees, the coverage under this **Certificate** will be primary. If the **Member** belongs to a covered group of less than 20 employees, Medicare benefits will be primary and benefits payable under this **Certificate** will be secondary provided the **Contract Holder** elects to continue coverage for the active **Subscriber** or the **Covered Dependent**.

Covered Persons Who Are Disabled or Who Have End Stage Renal Disease (ESRD).
Special rules apply to **Members** who are disabled or who have End Stage Renal Disease. This **Certificate** will make primary and secondary payer determination in accordance with the Omnibus Budget Reconciliation Act (OBRA), as amended.

Provision for Coordination with Medicare
HMO reserves the right to cover full benefits or to reduce benefits for any medical expenses covered under this **Certificate**. The amount **HMO** will pay will be figured so that the amount, plus the benefits under Medicare, will equal no more than 100% of **Allowable Expenses**. Charges for services used to satisfy a **Member's** Medicare Part B deductible will be applied under this **Certificate** in the order received by **HMO**. Two or more charges for services received at the same time will be applied starting with the largest first. Any rules for **Coordination of Benefits**, as outlined in this **Certificate**, will be applied after **HMO**'s benefits have been calculated under the rules in this section. **Allowable Expenses** will be reduced by any Medicare benefits available for those **Allowable Expenses**.

SUBROGATION AND RIGHT OF RECOVERY

If **HMO** provides health care benefits under this **Certificate** to a **Member** for injuries or illness for which another party is or may be responsible, then **HMO** retains the right to repayment of the full cost of all benefits provided by **HMO** on behalf of the **Member** that are associated with the injury or illness for which another party is or may be responsible. **HMO's** rights of recovery apply to any recoveries made by or on behalf of the **Member** from the following sources, including but not limited to: payments made by a third-party tortfeasor or any insurance company on behalf of the third-party tortfeasor; 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; any other payments from a source intended to compensate a **Member** for injuries resulting from an accident or alleged negligence.

The **Member** specifically acknowledges **HMO's** right of subrogation. When **HMO** provides health care benefits for injuries or illnesses for which another party is or may be responsible, **HMO** shall be subrogated to the **Member's** rights of recovery against any party to the extent of the full cost of all benefits provided by **HMO**. **HMO** may proceed against any party with or without the **Member's** consent.

The **Member** also specifically acknowledges **HMO's** right of reimbursement. This right of reimbursement attaches when **HMO** has provided health care benefits for injuries or illness for which another party is or may be responsible and the **Member** and/or the **Member's** representative has recovered any amounts from another party or any party making payments on the party's behalf. By providing any benefit under this **Certificate**, **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 **HMO**. **HMO's** right of reimbursement is cumulative with and not exclusive of **HMO's** subrogation right and **HMO** may choose to exercise either or both rights of recovery.

The **Member** and the **Member's** representatives further agree to:

A. Notify **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 injuries or illness sustained by the **Member** that may be the legal responsibility of another party;

B. Cooperate with **HMO** and do whatever is necessary to secure **HMO**'s rights of subrogation and/or reimbursement under this **Certificate**;

C. Give **HMO** a first-priority lien on any recovery, settlement or judgment or other source of compensation which may be had from any party to the extent of the full cost of all benefits associated with injuries or illness provided by **HMO** for which another party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement);

D. Pay, as the first priority, from any recovery, settlement or judgment or other source of compensation, any and all amounts due **HMO** as reimbursement for the full cost of all benefits associated with injuries or illness provided by **HMO** for which another party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by **HMO** in writing; and

E. Do nothing to prejudice **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 provided by **HMO**.

HMO may recover the full cost of all benefits provided by **HMO** under this **Certificate** without regard to any claim of fault on the part of the **Member**, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from **HMO's** recovery without the prior express written consent of **HMO**. In the event the **Member** or the **Member's** representative fails to cooperate with **HMO**, the **Member** shall be responsible for all benefits paid by **HMO** in addition to costs and attorney's fees incurred by **HMO** in obtaining repayment.

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 **Certificate** 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 **Subscriber'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 **Certificate**, 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 in this **Certificate**.

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 **Certificate** is for identification purposes only. Possession of an **HMO** identification card confers no right to services or benefits under this **Certificate**, and misuse of such identification card may be grounds for termination of **Member's** coverage pursuant to the Termination of Coverage section of this **Certificate**. 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 **Certificate**, the holder of the card must be a **Member** on whose behalf all applicable **Premium** charges under this **Certificate** have been paid. Any person receiving services or benefits which such person is not entitled to receive pursuant to the provisions of this **Certificate** 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 **Certificate** shall be terminated immediately, subject to the Administrative Complaints section in this **Certificate**.

B. **Reports and Records.** **HMO** is entitled to receive from any **Provider** of services to **Members**, information reasonably necessary to administer this **Certificate** subject to all applicable confidentiality requirements as defined in the General Provisions section of this **Certificate**. By accepting coverage under this **Certificate**, 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 **Certificate** 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 Utilization Review Determination Appeal, External Independent Review, and Administrative Complaints sections in this **Certificate**. 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 here under are personal to the **Member** and may not be assigned.

E. **Legal Action.** No action at law or in equity may be maintained against **HMO** for any expense or bill unless and until the appeal process has been exhausted, and in no event prior to the expiration of 60 days after written submission of claim has been furnished in accordance with requirements set forth in the **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.

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 **Certificate**.

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**. In the event a **PCP** terminates its contract or is terminated by **HMO**, **HMO** shall provide notification to **Members** in the following manner:

   a. within 30 days of the termination of a **PCP** contract to each affected **Subscriber**, if the **Subscriber** or any **Dependent** of the **Subscriber** is currently enrolled in the **PCP's** office; and

   b. services rendered by a **PCP** or **Hospital** to an enrollee between the date of termination of the Provider Agreement and 5 business days after notification of the contract termination is mailed to the **Member** at the **Member's** last known address shall continue to be **Covered Benefits**.

5. **Restriction on Choice of Providers:** Unless otherwise approved by **HMO**, **Members** must utilize **Participating Providers** and facilities who have contracted with **HMO** to provide services.

G. **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 **Certificate** is delayed or rendered impractical, **HMO** 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 **HMO** on the date such event occurs. **HMO** is 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.

H. **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 **Certificate**, or other activities, as permitted by applicable law. For other purposes, information may be disclosed only with the consent of the **Member**. **Members** can obtain a copy of **HMO's** Notice of Information Practices by calling the Member Services toll-free telephone number listed on the **Member's** identification card.

I. **Limitation on Services.** Except in cases of **Emergency Services** or **Urgent Care**, or as otherwise provided under this **Certificate**, 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**.

J. **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.

K. This **Certificate** applies to coverage only, and does not restrict a **Member's** ability to receive health care benefits that are not, or might not be, **Covered Benefits**.

L. **Contract Holder** hereby makes **HMO** coverage available to persons who are eligible under the Eligibility and Enrollment section of this **Certificate**. However, this **Certificate** 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 Illinois Department of Insurance. This can also be done by mutual written agreement between **HMO** and **Contract Holder** without the consent of **Members**.

M. **HMO** may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this **Certificate**.

N. No agent or other person, except an authorized representative of **HMO**, has authority to waive any condition or restriction of this **Certificate**, 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 **Certificate** shall be valid unless evidenced by an endorsement to it signed by an authorized representative of **HMO**.

O. This **Certificate**, including the Schedule of Benefits, any riders, and any amendments, endorsements, inserts, or attachments, constitutes the entire **Certificate** 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. 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 **Certificate**. No supplement, modification or waiver of this **Certificate** shall be binding unless executed in writing by authorized representatives of the parties.

P. This **Certificate** has been entered into and shall be construed according to applicable state and federal law.

Q. 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 **Certificate** shall have, unless the context clearly indicates otherwise, the meaning given to them below:

- **Allowable Expense(s).** Any **Medically Necessary** health expense, part or all of which is covered under any of the plans covering the **Member** for whom claim is made. A health care service or expense including **Deductibles**, coinsurance or **Copayments** that is covered in full or in part by any of the plans covering the **Member**, except as set forth below or where a statute requires a different definition. This means that an expense or service or a portion of an expense or service that is not covered by any of the plans is not an **Allowable Expense**. The following are examples of expenses or services that are not an **Allowable Expense**:

    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 patient'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 for private **Hospital** 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 the **Reasonable Charge,** any amount in excess of the lowest of the **Reasonable Charges** for a specified 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 lowest of the negotiated fees is not an **Allowable Expense**.

4. 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 lowest payment arrangement shall be the **Allowable Expense** for all plans.

5. The amount a benefit is reduced by the primary plan because a **Member** does not comply with the plan provisions is not an **Allowable Expense.** Examples of these provisions are second surgical opinions, pre-authorization requirements, and **Participating Provider** arrangements.

- **Behavioral Health Provider.** A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

- **Certificate.** This Evidence of Coverage, including the Schedule of Benefits, any riders, and any amendments, endorsements, inserts, or attachments, which outlines coverage for a **Subscriber** and **Covered Dependents** according to the **Group Agreement**.

- **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 ending at 12:00 midnight on the last day of the 1 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 2 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 **Certificate** for a description of the **Coordination of Benefits** provision.

- **Copayment.** The 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**.

- **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, physical appearance, or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. **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., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of **Cosmetic Surgery**.

- **Covered Dependent.** Any person in a **Subscriber's** family who meets all the eligibility requirements of the Eligibility and Enrollment section of this **Certificate** 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 **Certificate**, which are covered subject to all of the terms and conditions of the **Group Agreement** and **Certificate**.

- **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, any health benefit plan under section 5(e) of the Peace Corps Act, and the State Children's Health Insurance Program under Title XXI of the federal Social Security Act. **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 is provided in a separate policy.

- **Custodial Care.** Any type of care provided in accordance with Medicare guidelines, including room and board, that a) does not require the skills of technical or professional personnel; b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-hospital **Skilled Nursing Facility** care; or c) is a level such that the **Member** has reached the maximum level of physical or mental function and such person is not likely to make further significant improvement. **Custodial Care** includes, but is not limited to, any type of care where the primary purpose of the type of care provided is to attend to the **Member's** daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of this include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication which can be self-administered by the **Member**, general maintenance care of colostomy or ileostomy, routine services to maintain other service which, in the sole determination of **HMO's Medical Director or Designee**, based on medically accepted standards, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical or paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest cures, convalescent care.

- **Deductible.** The first payments up to a specified dollar amount which a **Member** must make in the applicable **calendar year** for **Covered Benefits**.

- **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.

- **Durable Medical Equipment (DME).** Equipment, as determined by **HMO's Medical Director or Designee**, which is a) made for and mainly used in the treatment of a disease or injury; b) made to withstand prolonged use; 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 **Certificate** as shown on the records of **HMO**.

- **Emergency Service.** Professional health services that are provided to treat a **Medical Emergency** and are available seven days per week and twenty-four hours per day.

- **Experimental or Investigational Procedures.** Services or supplies that are, as determined by **HMO's Medical Director or Designee**, 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, this **Certificate**, including the Schedule of Benefits, any riders, and any amendments, endorsements, inserts, or attachments, as subsequently amended by operation of law and as filed with and approved by the applicable public authority.

- **Health Professional(s).** 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.

- **Health Maintenance Organization (HMO).** Aetna Health Inc., an Illinois corporation licensed by the Illinois Department of Insurance as a **Health Maintenance Organization**.

- **Homebound Member.** A **Member** who is confined to the home due to an illness or injury which makes leaving the home medically contraindicated or which restricts the **Member's** ability to leave the **Member's** place of residence except with the aid of supportive devices, the use of special transportation, or the assistance of another person.

- **Home Health Services.** Those items and services provided by **Participating Providers** as an alternative to hospitalization, and coordinated and pre-authorized by **HMO's Medical Director or Designee**.

- **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's Medical Director or Designee**, and is focused on a palliative rather than curative treatment for **Members** who have a medical condition and a prognosis of less than 6 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's Medical Director or Designee** 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 (a) unable to conceive or produce conception after a period of 1 year of frequent, unprotected heterosexual sexual intercourse, or (b) unable to sustain a successful pregnancy. This 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.

- **Medical Community.** A majority of **Physicians** who are Board Certified in the appropriate specialty.

- **Medical Director or Designee.** A **Physician** designated by **HMO**, who is responsible for the administration of **HMO's** medical programs. The **Medical Director** may designate the Director of Medical Services to administer certain programs on his behalf.

- **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.** Services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards as described in the Covered Benefits section of this **Certificate**. **Medical Necessity**, when used in relation to services, shall have the same meaning as **Medically Necessary Services**. This definition applies only to the determination by **HMO** of whether health care services are **Covered Benefits** under this **Certificate**.

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

- **Mental or Behavioral Condition.** A condition which manifests signs and/or symptoms which are primarily mental or behavioral, for which the primary treatment is psychotherapy, psychotherapeutic methods or procedures, and/or the administration of psychotropic medication, regardless of any underlying physical or medical cause. Mental or behavioral disorders and conditions include, but are not limited to, psychosis, affective disorders, anxiety disorders, personality disorders, obsessive-compulsive disorders, attention disorders with or without hyperactivity, and other psychological, emotional, nervous, behavioral, or stress-related abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems, whether or not caused by or in any way resulting from chemical imbalance, physical trauma, or a physical or medical condition.

- **Non-Hospital Facility.** A facility, licensed by the appropriate regulatory authority, for the care or treatment of alcohol or drug dependent persons, except for transitional living facilities.

- **Open Enrollment Period.** A period each calendar year, when eligible enrollees 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**.

- **Physician(s).** 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(s).** 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 or a pediatrician to **Members**, initiates their **Referral** for **Specialist** care, and maintains continuity of patient care.

- **Prior Plan.** The plan of group health care benefits sponsored by the **Contract Holder** within 90 days prior to the effective date of this **Group Agreement** and which has been replaced by coverage under this **HMO**.

- **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's Medical Director or Designee** 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.

- **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.

- **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.

- **Service Area.** The geographic area established by **HMO** and approved by the appropriate regulatory authority.

- **Skilled Care.** Medical care that requires the skills of technical or professional personnel.

- **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 as a **Skilled Nursing Facility**, extended care facility, or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by **HMO's Medical Director or Designee** to meet the reasonable standards applied by any of the aforesaid authorities.

- **Specialist(s).** A **Physician** who provides medical care in any generally accepted medical or surgical specialty or subspecialty.

- **Subscriber.** A person who meets all applicable eligibility requirements as described in this **Certificate** 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.

- **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.

- **Women's Principal Health Care Provider**. A **Physician**, licensed to practice medicine in all of its branches, who is specializing in obstetrics or gynecology or specializing in family practice.

AETNA HEALTH INC.
(ILLINOIS)

CIVIL UNION AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. **Certificate** is hereby amended**.**

The Eligibility and Enrollment Section, A. Eligibility (2). is hereby deleted and replaced with the following:

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/civil union partner of a **Subscriber** under this **Certificate**.

   b. a dependent child (including natural, foster, step, legally adopted children, children placed for adoption, child(ren) of **Subscriber(s)** and of the legal spouse/civil union partner of the **Subscriber(s)**, a child under court order, dependents of dependents) who meets the eligibility requirements described in this **Certificate** and on the Schedule of Benefits.

   The term "spouse" shall include a party to a civil union as defined by Illinois State Law. In addition, if applicable, any references under this Certificate made to "marriage", "married", "husband", "wife", "family", "immediate family", "dependent", "next of kin", "widow", "widower", "widowed" or another word which in a specific context denotes a spousal relationship, the same shall include a civil union. In addition, a civil union or same sex civil union or marriage, and a substantially similar legal relationship other than common law marriage, entered into outside of Illinois which is valid under the law of another state or jurisdiction shall be valid in Illinois as a civil union.

   No individual may be covered both as an employee and dependent and no individual may be covered as a dependent of more than one employee.

The following is added to the **COBRA Continuation Coverage** section of the **Certificate**:

A **Subscriber**, who is a civil union partner, who is eligible for COBRA continuation of coverage, may elect COBRA continuation of coverage for the **Subscriber** and the **Subscriber's Covered Dependent**, including a civil union partner. However, a **Covered Dependent** who is a civil union partner, may not make a COBRA continuation of coverage election for themselves and their eligible dependents after any event that would otherwise give rise to COBRA rights, as they do not meet the federal definition of a "qualified beneficiary" under COBRA rules.

All other terms and conditions of the **Certificate** shall remain in full force and effect except as amended herein.

AETNA HEALTH INSURANCE COMPANY
(ILLINOIS)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. **Certificate** is hereby amended as follows:

The Exclusions and Limitations section of the **Certificate** is amended to delete the following exclusion:

- Costs for services resulting from the commission of, or attempt to commit a felony by the **Member**.

The Exclusions and Limitations section of the **Certificate** is amended to include the following exclusion:

- Costs for services resulting from the commission of, or attempt to commit a felony by the **Member**. This exclusion will not operate to deny benefits otherwise provided for treatment of an injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

AETNA HEALTH INC.
(ILLINOIS)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Covered Benefits section of the **Certificate** is hereby amended to include the following provision:

U. **General Anesthesia for Dental Care.**

General anesthesia and associated **Hospital** or ambulatory facility charges in conjunction with dental care provided to a **Member**, if the **Member** is determined by a licensed dentist in consultation with the **Member's PCP** to require these services to effectively and safely provide dental care; and

i. is under 6 years of age;
ii. is chronically disabled; or
iii. has a medical condition that requires admission to a **Hospital** or outpatient surgery facility and general anesthesia for dental care treatment.

Coverage is NOT provided for dental services associated with general anesthesia and associated **Hospital** or ambulatory facility charges, except as otherwise provided in this **Certificate** or in a rider to this **Certificate**.

AETNA HEALTH INC.
(ILLINOIS)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Conversion Privilege provision within the Continuation and Conversion section of the **Certificate** is hereby amended as follows:

3. **Member**s who are eligible for Medicare at the time their coverage under this **Certificate** is terminated are not eligible for conversion.

AETNA HEALTH INC.

(ILLINOIS)

COORDINATION OF BENEFITS AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The definitions of **Allowable Expense** and **Coordination of Benefits** shown in the Definitions section of the **Certificate** are hereby deleted.

The **Coordination of Benefits** section of the **Certificate** is deleted in its entirety and is replaced with the following:

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 **Members** 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**, unless the **Secondary Plan's** provider's contract prohibits any billing in excess of the provider's agreed upon rates.

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(s). 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 trusteed plans, labor organization plans, employer organization plans, or employee benefit organization plans;
5. Medical benefits coverage in a group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts;
6. Medicare or other governmental benefits;
7. 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 membership in or connection with a particular organization or group.

If the contract includes both medical and dental coverage those coverage's, will be considered separate **Plan's**. 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 is covered under this **Plan**.

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

When coverage under this **Certificate** 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 **Certificate** 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 **Certificate** 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 **Certificate** 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 coverage's that are superimposed over base plan providing **Hospital** and surgical benefits, and insurance type coverage's 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.

   If the other **Plan** does not have the rule described in this provision (a) but instead has a rule based on the gender of the parent and if, as a result, the **Plans** do not agree on the order of benefits, the rule in the other **Plan** will determine the order of benefits.

   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**. The same holds true if a person is a dependent of a person

covered as a retiree and an employee. 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 this section.

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, **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 **Plan's** 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 Certificate.

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 **Claim 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**.

Effect of Medicare on COB.

The following provisions explain how the benefits under this **Certificate** interact with benefits available under **Medicare**.

A **Member** is eligible for **Medicare** any time the **Member** is covered under it. **Members** are considered to be eligible for **Medicare** or other government programs if they:

1. Are covered under a program;

2. Have refused to be covered under a program for which they are eligible;

3. Have terminated coverage under a program; or

4. Have failed to make proper request for coverage under a program.

If a **Member** is eligible for **Medicare**, coverage under this **Certificate** will pay for such benefits as follows:

If a **Member's** coverage under this **Certificate** is based on current employment with the **Contract Holder**, coverage under this **Certificate** will act as the **Primary Plan** for the **Medicare** beneficiary who is eligible for **Medicare**:

1. solely due to age if this **Plan** is subject to the Social Security Act requirements for **Medicare** with respect to working aged (i.e., generally a plan of an employer with 20 or more eligible employees);

2. due to diagnosis of End Stage Renal Disease, but only during the first 30 months of such eligibility for **Medicare** benefits. But this does not apply if at the start of such eligibility the **Member** was already eligible for **Medicare** benefits and this **Plan's** benefits were payable on a **Secondary Plan** basis;

3. solely due to any disability other than End Stage Renal Disease; but only if this **Plan** meets the definition of a large group health plan in the Internal Revenue Code (i.e., generally a plan of an employer with 100 or more eligible employees).

Otherwise, coverage under this **Certificate** will cover the benefits as the **Secondary Plan**. Coverage under this **Certificate** will pay the difference between the benefits of this **Plan** and the benefits that **Medicare** pays, up to 100% of **Plan Expenses**.

Charges used to satisfy a **Member's** Part B deductible under **Medicare** will be applied under this **Plan** in the order received by **HMO**. Two or more charges received at the same time will be applied starting with the largest first.

Any rule for coordinating "other plan" benefits with those under this **Plan** will be applied after this **Plan's** benefits have been figured under the above rules.

Those charges for non-emergency care or treatment furnished by a **Member's Physician** under a Private Contract are excluded. A Private Contract is a contract between a **Medicare** beneficiary and a **Physician** who has decided not to provide services through **Medicare**.

This exclusion applies to services an "opt out" **Physician** has agreed to perform under a Private Contract signed by the **Member**. **Physicians** who have decided not to provide services through **Medicare** must file an "opt out" affidavit with all carriers who have jurisdiction over claims the **Physician** would otherwise file with **Medicare** and be filed no later than 10 days after the first private contract to which the affidavit applies is entered into with a **Medicare** beneficiary.

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 **Subscriber's**, the following will also apply:

- The **Members** 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**. **HMO** has the right to release or obtain any information and make or recover any payments 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 **Certificate**. 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 **Certificate**. **HMO** will not have to pay that amount again. The term "payment made" means 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.

AETNA HEALTH INC.

(ILLINOIS)

DEPENDENT CONTINUATION OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Continuation and Conversion section of the Aetna Health Inc. **Certificate** issued to large group **Contract Holders** with over 25 employees only is hereby amended as follows:

The following provisions are added to the Continuation and Conversion section of the **Certificate**:

- **Continuation of Coverage For Your Covered Dependents After Your Death, Retirement, or Dissolution of Marriage**

  If health coverage for your **Covered Dependents** would terminate due to your death, retirement, or dissolution of marriage while covered under any part of this **HMO** plan, any health coverage then in force for your **Covered Dependents** may be continued at the request of your covered surviving or former spouse. Continuation of the coverage must be requested in writing within 30 days of the date a notice of the right to continue is sent. **Premium** payments must be made for the coverage.

  Any **Covered Dependent's** coverage will cease on the first of the following to occur:

  - The end of a 2 year period after your death, retirement, or dissolution of marriage. This applies only if your covered surviving or former spouse was under age 55 on the date coverage is first continued under this section.
  - The date coverage would have terminated if you had not died, retired, or the marriage had not been dissolved. This will not apply during the first 120 days after your death, retirement, or dissolution of marriage unless coverage would have terminated due to a change in the group contract during such 120 days.
  - The date your surviving or former spouse remarries.
  - The date a dependent would have ceased to meet this **Certificate's** definition of a dependent, if you were living.
  - The date a dependent becomes covered for like coverage under this **Certificate** or another group plan.
  - The date dependent coverage under this **Certificate** is discontinued for the eligible class of which you were a member.
  - The end of the period for which any required contributions have been made.

- **Continuation of Coverage For Your Covered Dependent Children**

  Health coverage in force for your **Covered Dependent** children may be continued if that health coverage would terminate while covered under any part of this **HMO** plan due to:

  - your death, but that **Covered Dependent** child is not eligible for continuation under the above section, or
  - that **Covered Dependent** child's attainment of the age specified in the Schedule of Benefits, if any, at which the Covered Dependent would have lost eligibility.

  Continuation of the coverage must be requested in writing within 30 days of the date a notice of the right to continue is sent. **Premium** payments must be made for the coverage.

Any **Covered Dependent** child's coverage will cease on the first of the following to occur:

- The end of a 2 year period after the date this continuation began.
- The date a dependent becomes covered for like coverage under this **Certificate** or another group plan.
- The date dependent coverage under this **Certificate** is discontinued for the eligible class of which you were a member.
- The end of the period for which any required contributions have been made.

AETNA HEALTH INC.
(ILLINOIS)

EXTENSION OF BENEFITS AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. **Certificate** is hereby amended as follows:

CONTINUATION AND CONVERSION

Subsection C. Extension of Benefits Upon Total Disability of the Continuation and Conversion section of the **Certificate** is hereby deleted in its entirety and replaced with the following extension of benefits provisions:

C. **Extension of Benefits Upon Total Disability.**

Any **Member** who is **Totally Disabled** on the date coverage under this **Certificate** terminates is covered in accordance with the **Certificate**.

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's Medical Director or Designee**; 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; or

    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.

AETNA HEALTH INC.
(ILLINOIS)

CERTIFICATE OF COVERAGE AMENDMENT - DIABETES

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. **Certificate** is hereby amended as follows:

The Diabetic Supplies and Equipment provision of the Covered Benefits - Additional Benefits section is hereby replaced by the following:

- **Diabetic Supplies and Equipment.**

  Equipment, supplies, regular foot care exams, and education services for the treatment of type 1 diabetes, type 2 diabetes, and gestational diabetes mellitus are covered when **Medically Necessary** and when prescribed or ordered by the **Member's PCP**.

  Coverage also includes diabetic outpatient self-management training**, including medical nutrition education and education programs that allow the Member to maintain an A1c level within the range identified in nationally recognized standards of care. The coverage** shall be limited to the following: (1) 3 **Medically Necessary** visits to a **Provider** upon initial diagnosis of diabetes by the **Member's PCP**; and (2) 2 **Medically Necessary** visits to a **Provider** upon a determination by the **Member's PCP** that a significant change in the **Member's** symptoms or medical condition has occurred. A 'significant change' in condition means symptomatic hyperglycemia (greater than 250 mg/dl on repeated occasions), severe hypoglycemia (requiring the assistance of another person), onset of progression of diabetes, or a significant change in the medical condition that would require a significantly different treatment regimen.

AETNA HEALTH INC.
ILLINOIS

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Definitions section of the **Certificate** is amended to add the following:

- **Self-injectable Drug(s)**. Prescription drugs that are intended to be self administered by injection to a specific part of the body to treat certain chronic medical conditions. An updated copy of the list of **Self-injectable Drugs** that are not **Covered Benefits** shall be available upon request by the **Member** or may be accessed at the **HMO** website, at www.aetna.com. The list is subject to change by **HMO** or an affiliate.

The Injectable Medications Benefits in the Covered Benefits section of the **Certificate** is hereby deleted and replaced with the following:

- **Injectable Medications Benefits.**

  Injectable medications, except **Self-injectable Drugs** eligible for coverage under the Prescription Drug Rider, are a **Covered Benefit** when an oral alternative drug is not available, unless specifically excluded as described in the Exclusions and Limitations section of this **Certificate**. 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.

  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 1 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 1 study published in a nationally recognized peer reviewed journal.

AETNA HEALTH INC.
(ILLINOIS)

HOME HEALTH CARE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. **Certificate** is hereby amended as follows:

The Definitions of **"Custodial Care"**, **"Homebound Member"**, **"Skilled Care"** and **"Skilled Nursing Facility"** are hereby deleted and replaced with the following definitions:

- **Custodial Care.** Services and supplies that are primarily 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.

- **Homebound Member.** A **Member** who is confined to their place of residence 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.

- **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.

The **Home Health Benefits** provision under the Covered Benefits section of the **Certificate** is hereby deleted and replaced with the following:

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's Medical Director or Designee** by the **Member's** attending **Participating Physician**. **HMO** shall not be required to provide home health benefits when **HMO's Medical Director or Designee** 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.

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 **Certificate** and the Outpatient Rehabilitation section of the Schedule of Benefits.

The Private Duty Nursing exclusion under the Exclusions and Limitations section of the **Certificate** is hereby deleted and replaced with the following:

- Private Duty Nursing *(See the Home Health Benefits section regarding coverage of nursing services)*.

The Exclusions and Limitations section of the **Certificate** is hereby amended to include the following:

- Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).

AETNA HEALTH INC.
(ILLINOIS)

ENROLLMENT ENDORSEMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna U.S. Healthcare of Illinois Inc. **Certificate** is hereby amended as follows:

ELIGIBILITY AND ENROLLMENT

The Eligibility and Enrollment section of the **Certificate** 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 INC.
(ILLINOIS)

REHABILITATION AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The **Aetna Health Inc. Certificate** is hereby amended as follows:

The **Outpatient Rehabilitation Benefits** provision under the Covered Benefits section of the **Certificate** is hereby deleted and replaced with the following:

Rehabilitation Benefits.

The following benefits are covered when rendered by **Participating Providers** upon **Referral** issued by the **Member's PCP** and pre-authorized by **HMO's Medical Director or Designee**.

1. Cardiac and Pulmonary Rehabilitation Benefits.

   a. 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.

   b. 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.

2. Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits.

   Coverage is subject to the limits, if any, shown on the Schedule of Benefits. For inpatient rehabilitation benefits for the services listed below, refer to the Inpatient Hospital and Skilled Nursing Facility benefits provision under the **Covered Benefits** section of this **Certificate**.

   a. Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is coordinated with **HMO's Medical Director or Designee** as part of a treatment plan intended to restore previous cognitive function.

   b. Physical therapy is covered for non-chronic conditions and acute illnesses and injuries.

      Coverage is also provided for medically necessary Preventative Physical Therapy for the treatment of Multiple Sclerosis. For purposes of this section 2b, Preventative Physical Therapy means physical therapy that is prescribed by a **Physician** licensed to practice medicine in all of its branches for the purpose of treating parts of the body affected by multiple sclerosis, but only where the physical therapy includes reasonably defined goals, including, but not limited to, sustaining the level of function the Member has achieved, with periodic evaluation of the efficacy of the physical therapy against those goals.

   c. Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute illnesses and injuries.

   d. Speech therapy is covered for non-chronic conditions and acute illnesses and injuries.

Coverage is also provided for speech therapy for the treatment of Pervasive Developmental Disorders.

Therapies for the treatment of delays in developmentexcept for speech therapy for the treatment of Pervasive Developmental Disorders, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.

AETNA HEALTH INC.
(ILLINOIS)

COMPREHENSIVE INFERTILITY AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Definitions section of the **Certificate** is hereby amended to include the following defined terms:

- **Donor.** An egg donor or sperm donor.

- **Infertile or Infertility.** The condition of a presumably healthy **Member** who is (a) unable to conceive or produce conception after a period of 1 year of **Unprotected Sexual Intercourse**, or (b) unable to sustain a successful pregnancy. This does not include **Member** voluntary sterilization. However, a Member is considered **Infertile** without having to engage in 1 year of **Unprotected Sexual Intercourse**, if the **Member's Physician** determines that (a) a medical condition exists that renders conception impossible through **Unprotected Sexual Intercourse**, including but not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to chemotherapy or radiation treatments; or (b) efforts to conceive as a result of 1 year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful pregnancy.

- **Surrogate**. A woman who carries a pregnancy for a woman who has infertility coverage.

- **Unprotected Sexual Intercourse**. Should include appropriate measures to ensure the health and safety of sexual partners, and means a sexual union between a male and a female without the use of any process, device, or method that prevents conception, including but not limited to oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence or voluntary permanent surgical procedures.

Item R under the Covered Benefits section of the **Certificate** is hereby deleted and replaced with the following:

R. **Comprehensive Infertility Services.**

Infertility services and supplies to diagnose the underlying medical cause of **Infertility** are covered. Coverage is provided for the following outpatient services and supplies:

- In-vitro fertilization (IVF);
- Uterine embryo lavage;
- Embryo transfer;
- Artificial Insemination;
- Gamete intrafallopian tube transfer (GIFT);
- Zygote intrafallopian tube transfer (ZIFT); and
- Low tubal ovum transfer.
- Intracytoplasmic sperm injection (ICSI).

Covered Benefits also include the medical expenses of a known **Donor** for egg or sperm retrieval and the procedure used to transfer the eggs or sperm to the **Member**. If an egg **Donor** is used, the completed egg retrieval performed on the **Donor** will count against the **Member** as one completed egg retrieval for the purposes of the lifetime maximum.

If the **Member** is a female without a male partner attempting to become pregnant, Artificial Insemination is a **Covered Benefit** if the **Member** has had at least 12 cycles of **Donor** insemination (6 cycles for **Members** age 35 or older) prior to enrolling in **HMO's Infertility** program.

One completed egg retrieval could result in many IVF, GIFT, ZIFT, or ICSI procedures. There is no limit on the number of procedures, including less invasive procedures such as Artificial Insemination, until the final covered egg retrieval is completed.

Limitations

Covered Benefits will only include charges for the diagnosis and treatment of infertility, including prescription drug therapy, if the following tests are met:

- The **Member** has been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate **Infertility** treatments for which coverage is available under this Certificate. In the event that the **Member** or partner has a medical condition that renders such treatment useless, this requirement shall be waived.

- The **Member** has not undergone 4 completed egg retrievals, except that if a live birth follows a completed egg retrieval, then 2 more completed egg retrievals shall be covered. This applies to the **Member** per lifetime of that **Member**, for the treatment of **Infertility**, regardless of the source of payment. Once the final covered egg retrieval is completed, only 1 subsequent procedure used to transfer the egg or sperm to the covered recipient shall be covered.

- The procedures are performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

The exclusion for **Infertility** services, as provided in the Exclusions and Limitations subsection of the Covered Benefits section of the **Certificate** is hereby deleted and replaced with the following:

- **Infertility** services not explicitly covered, as provided in the Covered Benefits section of this **Certificate**. This exclusion includes, but is not limited to:
  1. Services for couples in which one of the partners has had a previous voluntary sterilization procedure, however in the event a voluntary sterilization is successfully reversed, **Infertility** benefits shall be available

  2. The purchase of **Donor** sperm and any charges for the storage of sperm;

  3. The purchase of **Donor** eggs and non-medical fees for an egg **Donor**;

  4. Any charges associated with care of the **Donor** required for gestational carriers;

  5. Any charges required for **Surrogates**, except medical costs for procedures to obtain eggs, sperm or embryos from a **Member** if the **Member** chooses a **Surrogate**;

  6. Charges associated with cryopreservation or storage of cryopreserved embryos (e.g., office, **Hospital**, ultrasounds, laboratory tests, etc.);

  7. Any service provided by a non-participating **Provider** or, in the case of Comprehensive **Infertility** Services, without a prior **Referral** or claim authorization from **HMO's Infertility** program case management unit;

  8. Home ovulation prediction kits;

  9. Drugs related to the treatment of non-covered benefits or related to the treatment of **Infertility** that are not **Medically Necessary**;

10. Fees associated with **Donor** egg programs, including but not limited to fees for laboratory tests and screening costs for potential egg **Donors**, as well as the payment to the **Donor**;

11. Reversal of sterilization surgery; and

12. **Medically Necessary** travel costs for travel within 100 miles of the **Member's** home address unless such travel was required by Aetna.

13. **Infertility** treatment for **Covered Dependents** under the age of 18.

14. Charges incurred after the maximum number of completed egg retrievals has been achieved, except for charges incurred for the 1 procedure used to transfer the egg or sperm to the covered recipient following the final completed egg retrieval for which coverage is available.

AETNA HEALTH INC.
(ILLINOIS)

TERMINATION OF COVERAGE

DISPUTE RESOLUTION, CLAIMS PROCEDURE, COMPLAINTS AND APPEALS AND EXTERNAL REVIEW CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. **Certificate** is hereby amended as follows:

1. All references to "grievance" in the **Certificate** are hereby changed to "**Complaint**".

2. The last 4 paragraphs of the Termination of Coverage section of the **Certificate**, and any amendments to those sections of the **Certificate**, are replaced by the following:

   A **Member** may register a **Complaint** with **HMO**, as described in the Claim Procedures, Complaints and Appeals, External Review and Dispute Resolution sections of the **Certificate**, after receiving notice that **HMO** has or will terminate the **Member's** coverage as described in the Termination for Cause subsection of the **Certificate**. **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. **HMO** may rescind coverage, to the date coverage would have terminated had the **Member** not registered a **Complaint** with **HMO**, if the final decision is in favor of **HMO**. If coverage is rescinded, **HMO** will provide the **Member** with a 30 day advance written notice prior to the date of the rescission, and refund any **Premiums** paid for any period after the termination date, minus the cost of **Covered Benefits** provided to the **Member** during this period.

   Coverage will not be terminated on the basis of a **Member's** health status or health care needs, nor if a **Member** has exercised the **Member's** rights under the **Certificate's** Claim Procedures, Complaints and Appeals, External Review, and Dispute Resolution sections to register a **Complaint** with **HMO**. The **Complaint** process described in the preceding paragraph applies only to those terminations affected pursuant to the Termination for Cause subsection of the **Certificate**.

   HMO shall have no liability or responsibility under this **Certificate** for services provided on or after 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 continue the **Members'** coverage beyond the date coverage terminates.

3. The Utilization Review and Grievance Procedure sections of the **Certificate**, and any amendments to these sections of the **Certificate** are replaced with the following:

CLAIM PROCEDURES

A claim occurs whenever a **Member** or the **Member's** authorized representative requests pre-authorization as required by the plan from **HMO**, a **Referral** as required by the plan from a **Participating Provider** or requests payment for services or treatment received. As an **HMO Member**, most claims do not require forms to be submitted. 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.

HMO will make a decision on the **Member's** claim**.** For urgent care and pre-service claims, the **HMO** will send the **Member** written notification of the determination, whether adverse or not adverse**.** For other types of claims, the **Member** may only receive notice if the **HMO** makes an adverse benefit determination.

"**Adverse benefit determinations**" are decisions made by **HMO** that result in denial, reduction, or termination of a benefit or the amount paid for it. It also means a decision not to provide a benefit or service. Such adverse benefit determination may be based on:

- The **Member's** eligibility for coverage.
- Coverage determinations, including plan limitations or exclusions.
- The results of any Utilization Review activities.
- A decision that the service or supply is an **Experimental or Investigational Procedure**.
- A decision that the service or supply is not **Medically Necessary.**

Written notice of an adverse benefit determination will be provided to the **Member** within the following time frames. Under certain circumstances, these time frames may be extended. The notice will provide important information that will assist the **Member** in making an **Appeal** of the adverse benefit determination, if the **Member** wishes to do so. Please see the Complaint and Appeals section of this **Certificate** for more information about **Appeals**.

HMO Timeframe for Notification of a Benefit Determination

Type of Claim	HMO Response Time from Receipt of Claim
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.	As soon as possible but not later than 72 hours after the claim is made. If more information is needed to make an **Urgent Care Claim** decision, **HMO** will notify the claimant within 72 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide **HMO** with the additional information. **HMO** will notify the claimant within 48 hours of the earlier to occur; • The receipt of the additional information; or • The end of the 48 hour period given the **Physician** to provide **HMO** with the information.

Pre-Service Claim. A claim for a benefit that requires pre-authorization of the benefit in advance of obtaining medical care.	Within 15 calendar days. **HMO** may determine that due to matters beyond its control an extension of this 15 calendar day claim decision period is required. Such as extension, of not longer than 15 additional calendar days, will be allowed if **HMO** notifies the **Member** within the first 15 calendar day period. If this extension is needed because **HMO** needs more information to make a claim decision the notice of the extension shall specifically describe the required information. The **Member** will have 45 calendar days, from the date of the notice, to provide **HMO** with the required information.
Concurrent Care Claim Extension. A request to extend a course of treatment previously pre-authorized by **HMO**.	If an urgent care claim, as soon as possible but not later than 24 hours provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. A decision will be provided not later than 15 calendar days with respect to all other care, following a request for a **Concurrent Care Claim Extension**.
Concurrent Care Claim Reduction or Termination. Decision to reduce or terminate a course of treatment previously pre-authorized by **HMO**.	With enough advance notice to allow the **Member** to file an **Appeal.** If the **Member** files an **Appeal**, **Covered Benefits** under the **Certificate** will continue for the previously approved course of treatment until a final **Appeal** decision is rendered. During this continuation period, the **Member** is responsible for any **Copayments** that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under **Appeal**. If **HMO's** initial claim decision is upheld in the final **Appeal** decision, the **Member** will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.
Post-Service Claim. A claim for a benefit that is not a pre-service claim.	Within 30 calendar days. **HMO** may determine that due to matters beyond its control an extension of this 30 calendar day claim decision period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if **HMO** notifies the **Member** within the first 30 calendar day period. If this extension is needed because **HMO** needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. The **Member** will have 45 calendar days, from the date of the notice, to provide **HMO**, with the required information.

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 or two levels, depending on the reason for the adverse benefit determination.

- **Complaint.** A **Complaint** is an expression of dissatisfaction about quality of care or the operation of the **HMO**.

- **External Review.** A review of an **adverse benefit determination** or a **final adverse benefit determination** by an Independent Review Organization/External Review Organization (ERO) assigned by the State Insurance Commissioner, and made up of **Physicians** or other appropriate **Providers**. The ERO must have expertise in the problem or question involved.

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. 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**, unless additional information is needed and it cannot be obtained within this time frame. The response will tell the **Member** what the **Member** needs to do to seek an additional review.

If the **Member** is not satisfied by **HMO's** resolution of any complaint, grievance or grievance appeal, the **Member** may appeal **HMO's** decision to the Illinois Department of Insurance.

B. **Full and Fair Review of Claim Determinations and Appeals.**

HMO will provide the **Member** with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue. This will be provided to the **Member** in advance of the date on which the notice of the **final adverse benefit determination** is required to be provided so that the **Member** may respond prior to that date.

Prior to issuing a **final adverse benefit determination** based on a new or additional rationale, the **Member** must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of **final adverse determination** is required.

C. **Appeals of Adverse Benefit Determinations.**

The **Member** will receive written notice of an adverse benefit determination 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 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**.

1. **Utilization Review.** The **HMO** provides for **Appeal** of a **Utilization Review** adverse benefit determination. The **Member** must complete the **HMO** review before bringing a lawsuit against the **HMO**. The following chart summarizes some information about how the **Appeals** are handled for different types of claims.

Utilization Review
HMO Timeframe for Responding to an Adverse Benefit Determination Appeal

Type of Claim	Level One Appeal HMO Response Time from Receipt of Appeal
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.	Within 24 hours Review provided by **HMO** 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 15 calendar days Review provided by **HMO** 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 15 calendar days Review provided by **HMO** personnel not involved in making the adverse benefit determination.

2. **Other Than Utilization Review.** The **HMO** provides for two levels of **Appeal** of an adverse benefit determination that is other than a **Utilization Review** adverse determination. The **Member** must complete the two levels of **HMO** review before bringing a lawsuit against the **HMO**. The following chart summarizes some information about how the **Appeals** are handled for different types of claims.

Other than Utilization Review
HMO Timeframe for Responding to an Adverse Benefit Determination Appeal

Type of Claim	Level One Appeal HMO Response Time from Receipt of Appeal	Level Two Appeal HMO Response Time from Receipt of Appeal
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.	Within 36 hours Review provided by **HMO** personnel not involved in making the **adverse benefit determination**.	Within 36 hours Review provided by **HMO** Appeals Committee. Review provided by **HMO** personnel not involved in making the **adverse benefit determination** or Level One **Appeal** decision.
Pre-Service Claim. A claim for a benefit that requires approval of the benefit in advance of obtaining medical care.	Within 15 calendar days Review provided by **HMO** personnel not involved in making the **adverse benefit determination.**	Within 15 calendar days Review provided by **HMO** Appeals Committee.
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	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 **HMO** personnel not involved in making the **adverse benefit determination**.	Within 30 calendar days Review provided by **HMO** Appeals Committee. Review provided by **HMO** personnel not involved in making the **adverse benefit determination** or Level One **Appeal** decision.

A **Member** and/or an authorized representative may attend the Level Two **Appeal** hearing and question the representative of **HMO** and/or any other witnesses, and present their case. The hearing will be informal. A **Member's Physician** or other experts may testify. **HMO** also has the right to present witnesses.

D. **Exhaustion of Process.**

The foregoing procedures and process are mandatory and must be exhausted prior to:

1. any investigation of a **Utilization Review Appeal** by the Department of Insurance; or

2. the filing of a **Utilization Review Appeal** with the Department of Insurance; or

3. the establishing of any litigation or arbitration, or any administrative proceeding regarding either any alleged breach of the **Group Agreement** or **Certificate** by **HMO,** or any matter within the scope of the **Complaints** and **Appeals** process.

Under certain circumstances a **Member** may seek simultaneous review through the internal Appeals Procedure and **External Review** processes – these include Urgent Care Claims and situations where the **Member** is receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.

Important Note:

If **HMO** does not adhere to all claim determination and **Appeal** requirements of the Federal Department of Health and Human Services, the **Member** is considered to have exhausted the **Appeal** requirements and may proceed with **External Review** or any of the actions mentioned above. There are limits, though, on what sends a claim or an **Appeal** straight to an **External Review**. A **Member's** claim or internal **Appeal** will not go straight to **External Review** if:

- a rule violation was minor and isn't likely to influence a decision or harm the **Member**;
- it was for a good cause or was beyond **HMO's** control; and
- it was part of an ongoing, good faith exchange between the **Member** and **HMO**.

E. **Record Retention.**

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

F. **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**.

EXTERNAL REVIEW

HMO may deny a claim and the **Member** may receive an **adverse benefit determination** or **final adverse benefit determination** because **HMO** determines that:

- Health care setting, level of care, or effectiveness requirements are not met;
- A preexisting condition was present before the effective date of coverage;
- Coverage has been rescinded due to a cancellation or discontinuance of coverage not due to a failure to timely pay required premiums;
- The care is not **Medically Necessary** or appropriate; or
- A service, supply or treatment is **Experimental or Investigational** in nature.

In these situations, the **Member** may submit a request for an **External Review** in writing to the Director of the Illinois Department of Insurance within 4 months after the date of the Member's receipt of an **adverse**

benefit determination or **final adverse benefit determination**, if the **Member** or the **Member's Provider** disagrees with **HMO's** decision.

The address and toll-free telephone number of the Office of Consumer Health Information within the Illinois Department of Insurance is:

320 West Washington Street, 4th Floor
Springfield, Illinois 62767
(877) 527-9431
(E-mail): http://insurance.illinois.gov/Complaints/file_complaint.asp

The notice of **adverse benefit determination** or **final adverse benefit determination** that the **Member** receives from **HMO** will describe the process to follow in detail if the **Member** wishes to pursue an **External Review**, and will include a copy of the *Request for External Review* form. Some of these processes are included below.

To request an **External Review**, any of the following requirements must be met:

- The **Member** has received an **adverse benefit determination** notice by **HMO,** and **HMO** did not adhere to all claim determination and **Appeal** requirements of the Federal Department of Health and Human Services.

- The **Member** has received a **final adverse benefit determination** notice of the denial of the claim by **HMO**.

- The **Member's** claim was denied because **HMO** determined that the care was not **Medically Necessary** or appropriate; health care setting, level or care, or effectiveness requirements are not met; or was **Experimental or Investigational**.

- The **Member** qualifies for a faster review as explained below.

- The **Member** has exhausted the applicable internal **Appeal** processes.

Within one business day after the date of receipt of an **External Review** request, the Director of the Illinois Insurance Department will send a copy of the request to **HMO**.

Within one business day after completion of a preliminary review of the **Member's External Review** request, **HMO** will notify the Director of the Illinois Department of Insurance, the **Member**, and if applicable, the **Member's** authorized representative in writing whether or not the **Member's** request is complete and eligible for **External Review**.

If the **Member's External Review** request is not complete, **HMO** will notify the Director of the Illinois Department of Insurance, the **Member**, and if applicable, the **Member's** authorized representative in writing and include the information or materials that are required by Illinois law in order to make the **Member's External Request** complete.

If the **Member's External Review** request is not eligible for **External Review**, **HMO** will notify the Director of the Illinois Department of Insurance, the **Member**, and if applicable, the **Member's** authorized representative in writing and include the reason(s) for the **Member's** request's ineligibility.

Whenever the Director of the Illinois Insurance Department receives notice that an **External Review** request is eligible for **External Review** following the preliminary review, within one business day following the date of receipt of the notice, the Director will assign an External Review Organization (ERO) and notify **HMO** of the name of the ERO. The Director of the Illinois Department of Insurance will also notify the **Member**, and if applicable, the **Member's** authorized representative in writing of the request's eligibility and acceptance for **External Review**, including the name of the ERO.

Upon receipt of the information and documents from **HMO**, and any other information the **Member**, and if applicable, the **Member's** authorized representative submits in writing to the ERO, the ERO will review.

Within one business day after the receipt of any information the **Member**, and if applicable, the **Member's** authorized representative submit, the ERO will forward the information to **HMO**. **HMO** may reconsider its **adverse benefit determination** or **final adverse benefit determination** that is the subject of the **External Review**.

If **HMO** decides to reverse its **adverse benefit determination** or **final adverse benefit determination**, within one business day after making that decision, **HMO** will provide a written notice to the Director of the Illinois Insurance Department, the **Member**, and if applicable, the **Member's** authorized representative of the decision. The ERO will terminate the **External Review** following receipt of notice from **HMO** of the decision to reverse its **adverse benefit determination** or **final adverse benefit determination**.

If **HMO** does not reverse its **adverse benefit determination** or **final adverse benefit determination**, within 5 days after the date of receipt of all necessary information, but not later than 45 days after the date of the receipt of the **External Review** request, the ERO will provide written notice of its decision to either uphold or reverse the **adverse benefit determination** or **final adverse benefit determination** to the Director of the Illinois Insurance Department**, HMO**, and the **Member**, and if applicable, the **Member's** authorized representative.

A faster review of the **Member's adverse benefit determination** by an ERO is possible if the **Member** or the **Member's Physician** certifies (by telephone or on a separate *Request for External Review* form) to the Director of the Illinois Insurance Department that a delay in receiving the service would:

- Seriously jeopardize the **Member's** life or health; or
- Jeopardize the **Member's** ability to regain maximum function; or
- If the **adverse benefit determination** relates to **experimental or investigational** treatment, if the **Physician** certifies that the recommended or requested health care service, supply or treatment would be significantly less effective if not promptly initiated.

The **Member** may also receive a faster review if the **adverse benefit determination** relates to an admission; availability of care; continued **stay;** or health service for which the **Member** received **Emergency Care**, but have not been discharged from a facility.

Faster reviews are decided by the ERO, as expeditiously as the covered person's medical condition or circumstance requires, but within 72 hours of the receipt of all pertinent information. Within this time frame, the ERO will notify the Director of the Illinois Insurance Department, **HMO**, the **Member**, the **Member's** health care provider, and if applicable, the **Member's** authorized representative of the decision. If this faster review decision was not communicated in writing by the ERO, then within 48 hours of the date of that notice, the ERO will provide written confirmation of its decision to the Director of the Illinois Insurance Department, **HMO**, the **Member**, and if applicable, the **Member's** authorized representative.

HMO will abide by the decision of the ERO, except where **HMO** can show conflict of interest, bias or fraud.

If an ERO performing an **External Review** upholds a decision adverse to the **Member**, and if applicable, the **Member's** authorized representative may appeal the decision to the Illinois Department of Insurance. The Director of the Illinois Department of Insurance may overturn the **External Review** decision.

The **Member** is responsible for the cost of compiling and sending the information that the **Member** wishes to be reviewed by the ERO to **HMO**. **HMO** is responsible for the cost of sending this information to the ERO and for the cost of the **External Review**.

For more information about the Complaints and Appeals or **External Review** processes, call the **Member Services** telephone number shown on the **Member's** ID card.

DISPUTE RESOLUTION

Any controversy, dispute or claim between **HMO** on the one hand and one or more **Members** 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 voluntary binding arbitration administered by the American Arbitration Association ("AAA") before a sole arbitrator ("Arbitrator"), provided that both HMO and Members mutually agree to the arbitration procedure. 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. This arbitration clause is not a substitute for the **Member's** right to maintain a legal action, and in no way affects or limits a **Member's** ability to take legal action in a court of law prior to voluntarily entering into an arbitration proceeding.

Any Claim alleging wrongful acts or omissions of **Participating** or non-participating **Providers** shall not include **HMO**. A **Member** must exhaust all **Complaint**, **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) **HMO** has made available independent external review and (ii) **HMO** has 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.

AETNA HEALTH INC.
(ILLINOIS)

COLORECTAL EXAMINATION AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

Item 4 of section **B. Diagnostic Services** of the **Covered Benefits** section of the **Certificate** is deleted in its entirety and is replaced with the following:

4. One of the following tests for **Members** age 50 and older, and for **Members** under age 50 who may be classified as high risk:

   - annual fecal occult blood test;
   - flexible sigmoidoscopy every 5 years;
   - annual fecal occult blood test and flexible sigmoidoscopy every 5 years;
   - double contrast barium enema every 5 years;
   - colonoscopy every 10 years.

AETNA HEALTH INC.
(ILLINOIS)

HIPAA SPECIAL ENROLLMENT/PORTABILITY AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. **Certificate** is amended as follows:

The **Special Enrollment Period** provision under the Eligibility and Enrollment section is deleted and replaced with the following:

6. Special Enrollment Period.

An eligible individual and eligible dependents may be enrolled during special enrollment periods. 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 requirements a, b, c and d 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**;

b. the eligible individual or eligible dependent declines coverage in writing under **HMO**;

c. the eligible individual or eligible dependent loses coverage under the other group health plan or other health insurance coverage for 1 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.

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;

- 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 **Certificate**; and

d. the eligible individual or eligible dependent enrolls within 31 days of the loss.

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 **Certificate**.

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 dependents enrolling during a special enrollment period will not be subject to late enrollment provisions, if any, described in this **Certificate**.

The Definition of **"Creditable Coverage"** is deleted and replaced with the following definition:

- **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 is provided in a separate policy.

AETNA HEALTH INC.
(ILLINOIS)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. **HMO Certificate** is amended as follows:

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

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/7days 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.

AETNA HEALTH INC.
(ILLINOIS)

CLAIM DETERMINATIONS AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The **Aetna Health Inc. Certificate** is hereby amended as follows:

1. Under sub-section B. **Limitations**, under the EXCLUSIONS AND LIMITATIONS section of the **Certificate**, the second bullet is hereby deleted and replaced with the following:

   - Determinations regarding eligibility for benefits, coverage for services, benefit denials and all other terms of this **Certificate** are made by **HMO's Medical Director or Designee,** subject to the terms of this **Certificate** and subject to the laws and regulations of the State of Illinois.

2. The Notice appearing at the close of sub-section B. **Limitations** is hereby deleted and replaced with the following:

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

AETNA HEALTH INC.
(ILLINOIS)

CERTIFICATE OF COVERAGE
AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The **Diagnostic Services Benefits** provision in the Covered Benefits section of the **Certificate** is hereby deleted and replaced with the following:

- **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's Medical Director or Designee** to a **Participating Provider**.

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

     - age 35 to 39, one baseline mammogram;
     - age 40 and older, 1 routine mammogram every year; or
     - when **Medically Necessary**.

  3. One Prostate Specific Antigen (PSA) blood test per calendar year; **Contract Year** for covered males age 40 and older.

  4. One colorectal cancer screening with sigmoidoscopy or fecal occult blood testing every three years for **Members** age 50 and older, and for **Members** who may be classified as high risk age 30 and older.

  5. Bone mass measurement for a qualified **Member** for the diagnosis and treatment of osteoporosis. A qualified **Member** is a **Member** with a condition for which bone mass measurement is determined to be **Medically Necessary**.

  6. One ovarian cancer screening using CA-125 serum tumor marker testing, transvaginal ultrasound, and a pelvic examination per **calendar year** for female **Members** who are at risk for ovarian cancer.

     "At risk for ovarian cancer" means:

     - Having a family history (i) with one or more first-degree relatives with ovarian cancer, (ii) of clusters of women relatives with breast cancer, or (iii) of nonpolyposis colorectal cancer; or
     - Testing positive for BRCA1 or BRCA2 mutations.

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AETNA HEALTH INC.
(ILLINOIS)

GENERAL PROVISIONS AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. **Certificate** is hereby amended as follows:

The Assignment of Benefits provision now appearing in Item D. of the **Certificate** Section entitled "General Provisions" is hereby deleted and replaced with the following.

D. **Assignment of Benefits.** All rights of the **Member** to receive benefits hereunder are personal to the **Member.** To the extent allowed by law, **HMO** may choose not to accept assignment to a provider including but not limited to an assignment of:

- The benefits due under the **Group Agreement**;
- The right to receive payments due under the **Group Agreement**; or
- Any claim the Member makes for damage resulting from a breach, or alleged breach, of the term of the **Group Agreement**.

HMO will notify the **Member** in writing, at the time it receives a claim, when an assignment of benefits to a health care **Provider** will not be accepted.

AETNA HEALTH INC.
(ILLINOIS)

BREAST ULTRASOUND SCREENING AMENDMENT

Contract Holder Effective Date: January 1, 2013

Item 2 of Section B. **Diagnostic Services** of the **Covered Benefits** section of the **Certificate** is hereby deleted and replaced by the following:

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's Medical Director or Designee** to a **Participating Provider**.

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

   - age 35 to 39, one baseline mammogram;
   - age 40 and older, 1 routine mammogram every year; or
   - when **Medically Necessary**.

   Comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when medically necessary as determined by a **Physician.**

AETNA HEALTH INC.
(ILLINOIS)

AMINO ACID-BASED ELEMENTAL FORMULA AMENDMENT

Contract Holder Effective Date: January 1, 2013

Section T. **Additional Benefits** of the **Covered Benefits** section of the **Certificate** is hereby amended by adding the following:

- **Amino Acid-Based Elemental Formula Benefit**

  The policy covers amino acid-based elemental formulas, regardless of delivery method, for the diagnosis and treatment of (i) eosinophilic disorders and (ii) short bowel syndrome when the prescribing **Physician** has issued a written order stating that the amino acid-based elemental formula is medically necessary.

  Coverage is payable at the same level as any other **Physician** expense.

AETNA HEALTH INC.
(ILLINOIS)

DEFINITION OF MENTAL OR BEHAVIORAL CONDITION AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Definition of Mental or Behavioral Condition of the Definitions section of the **Certificate** is hereby deleted and replaced by the following:

- **Mental or Behavioral Condition(s).** A condition which manifests signs and/or symptoms which are primarily mental or behavioral, for which the primary treatment is psychotherapy, psychotherapeutic methods or procedures, and/or the administration of psychotropic medication, regardless of any underlying physical or medical cause.

  Serious mental or behavioral disorders and conditions include schizophrenia, paranoid and other psychotic disorders, bipolar disorders (hypomanic, manic, depressive, and mixed), major depressive disorders (single episode or recurrent), schizoaffective disorders (bipolar or depressive), pervasive developmental disorders, obsessive-compulsive disorders, depression in childhood and adolescence, panic disorder, post-traumatic stress disorders (acute, chronic, or with delayed onset), and anorexia nervosa and bulimia nervosa.

  Non-serious mental or behavioral disorders and conditions include, but are not limited to, personality disorders, attention disorders with or without hyperactivity, and other psychological, emotional, nervous, behavioral, or stress-related abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems, whether or not caused or in any way resulting from chemical imbalance, physical trauma, or a physical or medical condition.

AETNA HEALTH INC.
(ILLINOIS)

DEPENDENT ELIGIBILITY AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The **Open Enrollment Period** provision of the **Eligibility and Enrollment** section of the **Certificate** is hereby revised as follows:

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**.

Eligible dependents may be enrolled during an annual **Open Enrollment Period**, if the dependent, as of the date on which the **Subscriber** elects dependent coverage, has a period of continuous **Creditable Coverage** of 90 days or more and has not been without **Creditable Coverage** for more than 63 days. A **Subscriber** may elect coverage for a dependent who does not meet the continuous **Creditable Coverage** requirements and that dependent shall not be denied coverage due to age.

The Handicapped Children provision of the **Eligibility and Enrollment** section of the **Certificate** is hereby revised as follows:

Handicapped Children.

Coverage is available for a child who is chiefly dependent upon the **Subscriber** for support and maintenance, and who is 26 years of age or older but incapable of self-support due to mental or physical incapacity. The incapacity must have commenced prior to the age the dependent would have lost eligibility. In order to continue coverage for a handicapped child, the **Subscriber** must provide evidence of the child's incapacity and dependency to **HMO** within 31 days of the date the child's coverage would otherwise terminate. Proof of continued incapacity, including a medical examination, must be submitted to **HMO** as requested, but not more frequently than annually beginning after the 2 year period following the child's attainment of the age specified on the Schedule of Benefits. This eligibility provision will no longer apply on the date the dependent’s incapacity ends.

The **Continuation and Conversion** section of the **Certificate** is hereby amended by adding the following:

Continuation Coverage for Dependent Students on Medical Leave of Absence

If a **Member**, who is eligible for coverage and enrolled in **HMO** by reason of his or her status as a full-time student at a postsecondary educational institution, ceases to be eligible due to:

1. a medically necessary leave of absence from school; or

2. a change in his or her status as a full-time student,

resulting from a serious illness or injury, such **Member's** coverage under the **Group Agreement** and this **Certificate** may continue.

Any **Covered Dependent's** coverage provided under this continuation provision will cease upon the first to occur of the following events:

1. the end of the 12 month period following the first day of the dependent child's leave of absence from school, or change in his or her status as a full-time student;

2. the dependent child's coverage would otherwise end under the terms of this plan;

3. the **Contract Holder** discontinues dependent coverage under this plan; or

4. the **Subscriber** fails to make any required contributions toward the cost of this coverage.

To be eligible for this continuation, the dependent child must have been enrolled in this plan and attending school on a full-time basis immediately before the first day of the leave of absence or the change in his or her status as a full-time student.

In order to continue coverage for a dependent child under this provision, the **Subscriber** must notify the **Contract Holder** as soon as possible after the child's leave of absence begins or a change in full time student status occurs. **HMO** may require a written certification from the treating **Physician** which states that the child is suffering from a serious illness or injury and that the resulting leave of absence (or other change in full-time student status) is medically necessary.

If:

1. a dependent child's eligibility under a prior plan is a result of his or her status as a full-time student at a postsecondary educational institution; and

2. such dependent child is in a period of coverage continuation pursuant to a medically necessary leave of absence from school (or change in full-time student status); and

3. this plan provides coverage for eligible dependents;

coverage under **HMO** will continue uninterrupted as to such dependent child for the remainder of the continuation period as provided above.

All other terms and conditions of the **Group Agreement** and this **Certificate of Coverage** shall remain in full force and effect except as amended herein.

The definition of **Creditable Coverage** in the **Definitions** section of the **Certificate** is hereby revised as follows:

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 in a separate policy.

The Dependent Eligibility section of the **Schedule of Benefits** is hereby deleted and replaced by the following:

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

i. **under 26 years of age; or**

ii. **under age 30, served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States, is an Illinois resident, has received an honorable release or discharge from the Armed Forces of the United States and has submitted to HMO a "Certificate of Release or Discharge from Active Duty", otherwise know as a DD2-14 (Member 4 or 6).**

iii. **26 but less than 30 years of age, not a military veteran, dependent on a parent or guardian Member, and attending a recognized college or university, trade or secondary school on a full-time basis; or**

iv. **chiefly dependent upon the Subscriber for support and maintenance, and is 26 years of age or older but incapable of self-support due to mental or physical incapacity, either of which commenced prior to: 26, or if a student but not a military veteran, 26 but less than 30.**

AETNA HEALTH INC.
(ILLINOIS)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Definition of **"HMO"** is deleted and replaced with the following definition:

HMO. Aetna Health Inc., a Pennsylvania corporation licensed by the Illinois Department of Insurance as a **Health Maintenance Organization.**

This Amendment shall be attached to and become part of the Plan Documents and is subject to all terms, conditions and limitations of the Plan Documents.

AETNA HEALTH INC.
(ILLINOIS)

PROSTHETIC APPLIANCES AND CUSTOMIZED ORTHOTIC DEVICES AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. **Certificate** is hereby amended as follows:

I. The Prosthetic Appliances Benefits provision shown under the Covered Benefits section of the **HMO** Evidence of Coverage is hereby deleted and replaced by the following:

O. **Prosthetic Appliances Benefits.**

The **Member's** initial provision and replacement of a prosthetic device 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's Medical Director or Designee**. Coverage includes repair and replacement when due to growth and development or a significant change in a **Member's** physical condition. Repair and replacement due to loss, misuse, abuse or theft are not covered. Accessories essential to the effective use of the device, 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 **Certificate**. **HMO** reserves the right to provide the most cost efficient and least restrictive level of service or items which can be safely and effectively provided.

II. The Durable Medical Equipment Benefits provision shown under the Covered Benefits section of the **HMO** Evidence of Coverage is hereby deleted and replaced by the following:

- **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:

- customized orthotic devices that provide support for the body or a part of the body, the head, neck, or extremities; and

- those items covered by Medicare unless excluded in the Exclusions and Limitations section of this **Certificate**.

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 made by the **HMO's Medical Director or Designee**.

Instruction and appropriate services required for the **Member** to properly use the item, such as attachment or insertion, is also covered upon pre-authorization by **HMO's Medical Director or Designee**. 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, as medically necessary; 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, loss, or abuse are a **Member's** responsibility.

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 **Certificate**.

AETNA HEALTH INC.
(ILLINOIS)

EVIDENCE OF COVERAGE DEPENDENT AGE NOTICE

Contract Holder Group Agreement Effective Date: January 1, 2013

The **HMO Procedure** section of the **Certificate** is hereby amended by the addition of the following notice:

NOTICE – DEPENDENT COVERAGE DICTATED BY IL HB 5285

Unmarried eligible **Covered Dependents** may be covered up to age 26.

Dependent coverage is available for eligible military veteran dependents. An eligible military veteran dependent must meet the following criteria in order to receive coverage.

An eligible military veteran dependent must:

- be unmarried;
- be under age 30;
- satisfy the eligibility requirements listed below; and
- be a resident of Illinois.

Eligibility for a Military Veteran Dependent

To be eligible for coverage to age 30, the military veteran dependent must:

- have served as a member of the active or Reserve Component of the Armed Forces of the United States, including the Illinois National Guard; and
- have received a release of discharge other than a dishonorable discharge, and
- submit proof of services using a DD2-14 (Member 4 or 6) form, otherwise known as a "Certificate of Release or Discharge from Active Duty." This form is issued by the federal government to all veterans. For more information on how to obtain a copy of a DD2-14, the veteran can call the Illinois Department of Veterans Affairs at 1-800-437-9824 or the U.S. Department of Veterans' Affairs at 1-800-827-1000.

Enrollment Period

An eligible dependent may be enrolled if a HIPAA special enrollment event occurs, such as loss of other coverage, discharge from the military, etc. The dependent must be added within 30 days of the event that qualified him or her for special enrollment. In addition, an eligible dependent may be enrolled during the group's annual open enrollment period.

Eligible dependents enrolling due to a HIPAA special enrollment event or during the annual open enrollment period may be subject to the plan's pre-existing condition exclusion.

AETNA HEALTH INC.
(ILLINOIS)

SCHEDULE OF BENEFITS

AMENDMENT

The Aetna Health Inc. Schedule of Benefits is hereby amended as follows:

The **Outpatient Rehabilitation** Benefit is hereby replaced by the following:

OUTPATIENT BENEFITS

Benefit	Copayment
Outpatient Physical, Occupational, and Speech Therapy	
60 combined Physical, Occupational, and Speech Therapy visits per calendar year	**$20 per visit**
20 additional speech therapy visits for treatment of Pervasive Developmental Disorders per calendar year	

AETNA HEALTH INC.
(ILLINOIS)

HIPAA/CHIPRA SPECIAL ENROLLMENT AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. **Certificate**, and/or any applicable amendment to the **Certificate** is hereby amended as follows:

The **Special Enrollment Period** provision under the Eligibility and Enrollment section is deleted and replaced with the following:

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**;

b. the eligible individual or eligible dependent previously declined coverage [in writing] under **HMO**;

c. the eligible individual or eligible dependent becomes eligible for State premium assistance in connection with coverage under **HMO**.

d. 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;

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;
- 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 **Certificate**.

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

a. 31days, 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.

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 **Certificate**.

AETNA HEALTH INC.
(ILLINOIS)

COMPASSIONATE CARE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. **Certificate** is hereby amended as follows:

1. The **Hospice Care** definition in the Definitions section of the **Certificate** is deleted and replaced with the following:

   - **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.

Exhibit A

AETNA HEALTH INC.
ILLINOIS

PPACA Endorsement Template

PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010
Non-grandfathered GROUP CERTIFICATE **RIDER**

The Certificate, to which this rider is attached and becomes a part, is amended as stated below.

A new section titled "Patient Protection and Affordable Care Act" is hereby added to the Certificate as follows:

PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

Effective January 1, 2013, some of the benefits, terms, conditions, limitations, and exclusions contained in Your Certificate will change as a result of the Patient Protection and Affordable Care Act of 2010. Notwithstanding any other provision of Your Certificate, the provisions below shall apply. In the event of a conflict between the provisions of any other Section of Your Certificate and the provisions of this Rider, the provisions of this Rider shall prevail, except to the extent the provisions of Your Certificate are more beneficial to You than are the provisions of this Rider.

Definitions

For the purposes of this Rider, the following definitions shall apply:

"Essential health benefits" means benefits covered under the Certificate, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care. Such benefits shall be essential health benefits only to the extent required by the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

"Patient Protection and Affordable Care Act of 2010" means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Lifetime Dollar Limits

If Your Certificate contains a lifetime dollar maximum on the value of all benefits, such lifetime dollar maximum no longer applies. If Your Certificate contains a lifetime dollar maximum(s) on the value of specific benefits that are Essential Health Benefits, such lifetime dollar maximum(s) no longer apply.

If coverage under this Certificate, for You or another person in Your family, ended by reason of reaching a lifetime dollar maximum, and You or Your family member are eligible for benefits under this Certificate, You will receive written notice that You or Your family member are once again eligible for benefits under this Certificate. If Your family member is no longer enrolled under this Certificate, he or she will be given an opportunity to re-enroll. We must provide You this written notice and, if applicable, the opportunity to re-enroll, within 30 days from the date you receive the notice.

Annual Dollar Limits

Essential Health Benefits provided within Your Certificate are not subject to any annual dollar maximum(s).

Rescissions

We may not rescind Your Certificate based on a misrepresentation by You unless You have performed an act or practice that constitutes fraud, or made an intentional misrepresentation of material fact, as prohibited by the terms of Your Certificate. We must provide at least 30 days' advance written notice before Your Certificate may be rescinded. You have the right to appeal any such rescission.

Preventive Services

In addition to the Covered Benefits listed in the Covered Benefits section of Your Certificate, the following services shall be covered without regard to any deductible, copayment, or coinsurance requirement that would otherwise apply:

(1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
(3) with respect to Covered Persons who are infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
(4) with respect to Covered Persons who are women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

For purposes of this section, recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current. No recommendation of the United States Preventive Service Task Force shall serve to reduce the mammogram benefits required by Illinois law and described in the Covered Benefits section of your Certificate.

Extension of Coverage to Dependents

Notwithstanding the eligibility requirements described in the Dependent Eligibility provision of the Schedule of Benefits section of Your Certificate, a child in Your family is eligible to become a Covered Person if the child: 1) is under age 26, and 2) is related to You by one of the relationships listed in the Eligibility and Enrollment section of Your Certificate.

A child in Your family who is age 26 or older is also eligible to become a Covered Person if the child: 1) is an Illinois resident; 2) served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States; 3) received a release or discharge other than a dishonorable discharge; 4) is under age 30; and 5) meets any additional eligibility requirements described in the Dependent Eligibility provision of the Schedule of Benefits section of Your Certificate and the Eligibility and Enrollment section of Your Certificate.

Right to Appeal

You have the right to appeal any decision or action taken by Us to deny, reduce or terminate the provision of or payment for health care services requested or received under Your Certificate. When We have denied, reduced, or terminated a requested service or payment for a service covered by Your Certificate based on a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service, You have the right to have Our decision reviewed by an independent review organization not associated with Us.

We must provide you with certain written information, including the specific reason for Our decision and a description of Your appeal rights and procedures, every time We make a determination to deny, reduce or terminate the provision of or payment for health care services requested or received under Your Certificate.

Emergency Services

We shall cover Emergency Services without the need for any prior authorization determination and without regard as to whether the health care provider furnishing such services is a Participating Provider. Care provided by a Non-Participating Provider will be paid at no greater cost to the Covered Person than if the services were provided by a Participating Provider.

Direct Access to Obstetricians and Gynecologists

In addition to the Woman's Principal Health Care Provider described in the HMO Procedure and Covered Benefits sections of Your Certificate, a female Covered Person may see any available participating health care professional who specializes in obstetrics or gynecology without referral from her Primary Care Provider.

Obstetrical and gynecological care authorized or ordered by a health care professional who specializes in obstetrics or gynecology will be treated as authorized by the Primary Care Provider.

Selection of a Primary Care Provider

You may designate any available participating Primary Care Provider who is available to accept You to be Your Primary Care Provider as required under the HMO Procedure section of Your Certificate.

Your child's legal representative may designate a physician (allopathic or osteopathic) who specializes in pediatrics as his or her Primary Care Provider as required under the HMO Procedure section of Your Certificate.

Preexisting Condition Limitations

With respect to Covered Persons who are under 19 years of age, notwithstanding any Preexisting Condition Limitations described in the Exclusions and Limitations Section of Your Certificate/Rider, no health care service or treatment will be denied, limited, or excluded based on the fact that a medical condition was present before the effective date of Your Certificate, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day.

With respect to Covered Persons who are under 19 years of age, any provision previously attached to the Certificate excluding coverage for a specific condition is removed and shall be considered null and void.

Questions/Contact Information

Questions regarding this Rider can be directed to Aetna's Member Services using the phone number shown on the back of your ID Card. You may also contact the Illinois Department of Insurance at (877) 527-9431 or http://insurance.illinois.gov.

This Rider takes effect on the effective date of the Certificate to which it is attached. This Rider terminates concurrently with the Certificate to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Certificate except as stated.

AETNA HEALTH INC.
(ILLINOIS)

STATE CONTINUATION AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. **Certificate** is hereby amended as follows:

CONTINUATION AND CONVERSION

Subsection B. Continuation of Coverage – State of Illinois, of the Continuation and Conversion section of the **Certificate**, is hereby deleted in its entirety and replaced with the following:

B. **Continuation of Coverage - State of Illinois.**

1. **Eligibility:**

In the event of termination of employment or membership, **Members** who have been continuously enrolled under **HMO** for 3 months prior to termination**,** are entitled to continue coverage. A Member who is involuntarily terminated between September 1, 2008 and December 31, 2009 is also entitled to continue coverage, provided the Member is covered under this Certificate the day prior to such termination. Upon termination, the **Contract Holder** will send the **Member** written notice of the availability of continuation. Continuation will not be available to any **Member** if termination of employment is the result of commission of a felony or theft in connection with the **Member's** work and the **Member** admits to or is convicted of such felony or theft.

2. **Enrolling for Continuation:**

A **Member** must request continuation, in writing, within the 30 day period following the later of (a) the date of termination or (b) the date the **Member** is given written notice of the right to continuation by the **Contract Holder**. In no event shall the **Member** elect continuation more than 60 days after the date of termination.

3. **Contributions:**

A **Member** electing continuation must pay to the **Contract Holder**, on a monthly basis in advance, the total amount of **Premium** due. This amount will not be more than the **Contract Holder** rate (subject to any increases the **Contract Holder** may receive).

4. **Coverage Provided:**

If coverage is continued under this section, the **Member** will continue to be covered under this **Group Agreement**. The continued coverage is subject to the conditions, limitations and exclusions of the **Group Agreement**. The **HMO** will not issue a new **Certificate** to continuing **Members**. The **HMO** and the **Contract Holder** may agree to change the **Group Agreement** after the **Member** enrolls for continued coverage and the continuing **Member's** coverage will be subject to such changes.

5. **Duration and Termination of Continuation of Coverage:**

Coverage for a **Member** will cease on the first to occur of:

- The end of the 12 month period which starts on the date coverage would otherwise stop;
- The date the **Member** becomes eligible for Medicare;
- The date the **Member** becomes covered by any other Group medical plan;

- The date the **Member** fails to make the contributions needed;
- The date coverage discontinues as to employees of **Contract Holder;** or
- The date coverage would otherwise terminate as set forth elsewhere in this **Certificate**.

Coverage for a **Covered Dependent** will stop earlier when the person:

- Ceases to be eligible as a **Covered Dependent**;
- Becomes eligible for other coverage under the **Group Agreement**; or
- The date coverage would otherwise terminate as set forth elsewhere in this **Certificate**.

6. **Conversion:**

If any coverage being continued under this section terminates because the end of the maximum period of continuation has been reached, conversion of coverage will be available at the end of such period on the same terms as those set forth in the "Conversion" section below.

This Amendment shall be attached to and become part of the Plan Documents and is subject to all terms, conditions and limitations of the Plan Documents.

AETNA HEALTH INC.
(ILLINOIS)

AETNA OPEN ACCESS RIDER

Contract Holder Group Agreement Effective Date: January 1, 2013

HMO and **Contract Holder** agree to provide **Covered Benefits** under this plan as described below and subject to the provisions of this Rider. The **Member** may obtain certain **Covered Benefits** from **Participating Providers** without a **Referral** from their selected **PCP**.

Item A under the **HMO** Procedure section of the **Certificate** is amended to delete the following sentence:

Until a **PCP** is selected, benefits will be limited to coverage for **Medical Emergency** care.

Item B under the **HMO** Procedure section of the **Certificate** is deleted and replaced with the following:

B. **The Primary Care Physician (PCP).**

The **PCP** provides services for the treatment of routine illnesses, injuries, well baby and preventive care services which do not require the services of a **Specialist**, and for after hours services or on-call coverage services under this plan to give **Members Medical Emergency** or **Urgent Care** services instructions in the event of an after hours injury or sickness. If the **Member's PCP** is not reasonably available to provide services to the **Member**, the **Member** may access **Urgent Care** from a **Participating Urgent Care** facility within the **HMO Service Area**. The **Member's** selected **PCP** or that **PCP's** covering **Physician** is required to be available 7 days a week, 24 hours a day for services.

A **Member** is encouraged to select a **PCP** for themselves and for each of their **Covered Dependents** at the time of enrollment, however this is not a plan requirement. If a **Member** selects a **PCP**, the **Member** may change their **PCP** at any time by contacting **HMO**.

A **Member** who selects a **PCP** will be subject to the **PCP Copayment** listed on the Schedule of Benefits when a **Member** obtains **Covered Benefits** from their selected **PCP**. A **Member** may obtain **Covered Benefits** from other **Participating PCPs**. However, a **Member** will be subject to the **Specialist Copayment** listed on the Schedule of Benefits when a **Member** accesses a **PCP** other than their selected **PCP**. A **Member** who does not select a **PCP** will be subject to the **Specialist Copayment** listed on the Schedule of Benefits when a **Member** obtains **Covered Benefits** from any **Participating PCP** or **Participating Specialist**.

Certain **PCP** offices are affiliated with integrated delivery systems or other provider groups (i.e., Independent Practice Associations and Physician-Hospital Organizations), and **Members** who select these **PCPs** will generally be referred to **Specialists** and **Hospitals** within that system or group. However, if the group does not include a **Provider** qualified to meet the **Member's** medical needs, the **Member** may request to have services provided by nonaffiliated **Providers**.

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, according to the exclusions and limitations section of this Evidence of Coverage, will be the **Member's** responsibility. Before beginning any course of treatment, including an elective one, **Members** should first review their Evidence of Coverage and/or contact Member Services at the phone number listed on the **Member's** I.D card to determine whether or not the course of treatment is a **Covered Benefit**..

The **Covered Benefits** section of the **Certificate** is amended to include the following provisions:

- **Self-Referred Services.**

  Except as described in the Exclusions and Limitations section of this Rider, the **Certificate**, any amendments and/or riders are hereby revised to remove the requirement that a **Member** must obtain a **Referral** from their **PCP** prior to accessing **Covered Benefits** from **Participating Providers**.

  Under this provision, a **Member** may directly access **Participating Specialists**, ancillary **Providers** and facilities for **Covered Benefits** without a **PCP Referral**, subject to the terms and conditions of the **Certificate** and any cost-sharing requirements set forth in the Schedule of Benefits. **Participating Providers** will be responsible for obtaining pre-authorization of services from **HMO's Medical Director or Designee**.

  Except as described in this Rider, the **Covered Benefits** section and the Exclusions and Limitations section of the **Certificate** remain unchanged and the ability of a **Member** to directly access **Participating Providers** does not alter any other provisions of the **Certificate**. Except for **Emergency Services** and out-of-area **Urgent Care** services, a **Member** must access **Covered Benefits** from **Participating Providers** and facilities or benefits will not be covered under this **Certificate** and a **Member** will be responsible for all expenses incurred unless **HMO's Medical Director or Designee** has pre-authorized the services to a non-participating **Provider**.

The Exclusions and Limitations section of the **Certificate** is amended to delete the following exclusion:

- Unauthorized services, including any service obtained by or on behalf of a **Member** without a **Referral** issued by the **Member's PCP** or pre-authorized by **HMO's Medical Director or Designee**. This exclusion does not apply in a **Medical Emergency** or in an **Urgent Care** situation or when it is a direct access benefit.

The Exclusions and Limitations section of the **Certificate** is amended to include the following exclusion:

- Unauthorized services obtained by the **Member** that require pre-authorization by **HMO's Medical Director or Designee** including but not limited to **Hospital** admissions and outpatient surgery. **Participating Providers** are responsible for obtaining pre-authorization of **Covered Benefits** from **HMO's Medical Director or Designee**.

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

- Upon pre-authorization, other treatment plans may be subject to case management and a **Member** may be directed to specific **Participating Providers** for **Covered Benefits** including, but not limited to transplants and other treatment plans.

- Supplemental plans provided under a separate contract or policy in addition to an **HMO** health benefit plan, including but not limited to dental plans and behavioral health plans, are not subject to the provisions of this Rider and a **Member** is required to abide by the terms and conditions of the separate contract or policy.

The Continuation and Conversion section of the **Certificate** is amended to include the following provision:

- The conversion privilege does not apply to the Aetna Open Access Rider.

Aetna Health Inc.
(Illinois)

DOMESTIC PARTNER RIDER

Contract Holder Group Agreement Effective Date: January 1, 2013

The Domestic Partner rider for this contract is effective January 1, 2013.
Subsection A.2.a of the Eligibility and Enrollment section of the **Certificate** is hereby deleted and replaced with the following:

a. the legal spouse or domestic partner of a **Subscriber** under this **Certificate**, and who, as of the date of enrollment (with respect to a domestic partner):

i. provides proof of cohabitation (e.g. driver's license or tax return);
ii. are both of the age of consent in their state of residence;
iii. are not related by blood in any manner that would bar marriage in their state of residence;
iv. have a close, committed and monogamous personal relationship;
v. have been sharing the same household on a continuous basis for at least 6 months;
vi. have registered as domestic partners where such registration is available;
vii. is not married to, or separated from, another individual;
viii. have not been registered as a member of another domestic partnership within the last six months; and
ix. demonstrates financial interdependence by submission of proof of three or more of the following:

a) common ownership of real property or a common leasehold interest in such property;
b) common ownership of a motor vehicle;
c) joint bank accounts or credit accounts;
d) designation as a beneficiary for life insurance or retirement benefits, or under the partner's will;
e) assignment of a durable power of attorney or health care power of attorney; or
f) such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case.

HMO may request documentation of any of the foregoing prior to commencing coverage for a domestic partner; or

AETNA HEALTH INC.
(ILLINOIS)

PRESCRIPTION LENS ALLOWANCE RIDER

Contract Holder Group Agreement Effective Date: January 1, 2013

Aetna Health 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 **Certificate** is amended to add the following provision:

- **Prescription Lens 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.

The Continuation and Conversion section of the **Certificate** is hereby amended to add the following provision:

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

AETNA HEALTH INC.
ILLINOIS

MORBID OBESITY SURGICAL TREATMENT RIDER

Contract Holder Group Agreement Effective Date: January 1, 2013

Aetna Health Inc., ("**HMO**") and **Contract Holder**, agree to provide to **Members** the Morbid Obesity Surgical Treatment Rider subject to the following provisions:

The Definitions section of the **Certificate** is hereby amended to add the following definition(s):

- **Body Mass Index.** A practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

- **Morbid Obesity. A Body Mass Index** that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a high risk comorbid medical condition, including significant cardiovascular disease, sleep apnea, or uncontrolled type-2 diabetes.

The Covered Benefits section of the **Certificate** is hereby amended to add the following benefit(s):

- **Morbid Obesity Surgical Benefits**

  Surgical treatment of **Morbid Obesity** is a **Covered Benefit**, when provided by a **Participating Provider** and when authorized in advance by **HMO**. Coverage includes one surgical procedure within a two-year period, beginning with the date of the first **Morbid Obesity** surgical procedure, unless a multi-stage procedure is planned and approved by **HMO**.

  Coverage for Morbid Obesity Surgical benefits are only provided for referred care.

  Refer to the Schedule of Benefits attached to this **Certificate** for applicable cost sharing provisions.

The following exclusions are hereby deleted from the Exclusions and Limitations section of the **Certificate**:

- Surgical operations, procedures or treatment of obesity, except when pre-authorized by **HMO**.

- Weight reduction programs, or dietary supplements.

The Exclusions and Limitations section of the **Certificate** is hereby amended to add the following exclusion(s):

- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including **Morbid Obesity**, or for the purpose of weight reduction**,** regardless of the existence of comorbid conditions; except as provided by this rider.

The Continuation and Conversion section of the **Certificate** is hereby amended to add the following provision:

The conversion privilege, if any, does not apply to the Morbid Obesity Surgical Treatment Rider.

The Schedule of Benefits is hereby amended to add the following:

MORBID OBESITY SURGICAL TREATMENT BENEFITS

Benefit	Deductible/Copayment/Maximums
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services).	**Refer to the Schedule of Benefits for applicable cost sharing provisions.**

Copayment(s) for **Morbid Obesity** services do not apply to the Maximum Out-of-Pocket Copayment Limit, if any, listed in the Schedule of Benefits.

AETNA HEALTH INC.
(ILLINOIS)

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 **Certificate** 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**. This rate does not reflect or include any amount **HMO** or an affiliate may receive under a rebate arrangement between **HMO** or an affiliate and a drug manufacturer for any drugs, including any drugs on the **Drug Formulary**.

- **Drug Formulary**. A list of prescription drugs and insulin established by **HMO** or an affiliate, which includes both **Brand Name Prescription Drugs,** and **Generic Prescription Drugs**. This list is subject to periodic review and modification by **HMO** or an affiliate. A copy of the **Drug Formulary** will be available 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 at the sole discretion of **HMO**.

- **Generic Prescription Drug(s)**. Prescription drugs and insulin, whether identified by their chemical, proprietary, or non-proprietary name, that are 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** or an affiliate.

- **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**.

- **Participating Mail Order Pharmacy.** A pharmacy, which has contracted with **HMO** or an affiliate 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** or an affiliate to provide covered outpatient prescription drugs to **Members**.

- **Precertification Program.** For certain outpatient prescription drugs, prescribing **Physicians** must contact **HMO** or an affiliate to request and obtain coverage for such drugs. The list of drugs requiring precertification is subject to change by **HMO** or an affiliate. An updated copy of the list

of drugs requiring precertification shall be available upon request by the **Member** or may be accessed at the pharmacy website, at www.aetna.com.

- **Step Therapy Program.** A form of precertification under which certain prescription drugs will be excluded from coverage**,** unless a first-line therapy drug(s) is used first by the **Member**. The list of step therapy drugs is subject to change by **HMO** or an affiliate. An updated copy of the list of drugs subject to step therapy shall be available upon request by the **Member** or may be accessed at the pharmacy website, at www.aetna.com.

- **Therapeutic Drug Class.** A group of drugs or medications that have a similar or identical mode of action or exhibit similar or identical outcomes for the treatment of a disease or injury.

COVERED BENEFITS

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

A. **Outpatient Prescription Drug Open Formulary 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 **Certificate**. Coverage is based on **HMO's** or an affiliate's determination, in its sole discretion, if a prescription drug is covered. Some items are covered only with pre-authorization 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**.

B. Each prescription is limited to a maximum 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, in **HMO's** sole discretion, be subject to **Precertification**, the **Step Therapy Program** or other **HMO** requirements or limitations.

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, 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), or 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. Coverage of off label use of these drugs may, in **HMO's** sole discretion, be subject to the **Precertification Program**, the **Step Therapy Program** or other **HMO** requirements or limitations.

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 below and any **Brand Name Prescription**

Drug cost differentials as applicable. 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),** plus the **Brand Name Prescription Drug** cost differentials where applicable and as described below. **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** in its sole discretion. **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.
  6. FDA approved oral agents used to control blood sugar.
  7. Glucagon emergency kits.

- **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**.**
  3. Injectable contraceptives, the prescription plan **Copayment** applies for each vial up to a maximum of 5 vials per calendar year.
  4. Contraceptive patches
  5. Contraceptive rings
  6. Norplant and IUDs are covered when obtained from a **Participating Physician.** The **Participating Physician** will provide insertion and removal of the device.

An office visit **Copayment** will apply, if any. A **Copayment** for the contraceptive device may also apply.

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 at the time the prescription is dispensed. If the **Member** obtains more than a30 day supply of prescription drugs or medicines at the **Participating Retail** or **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**	**$40**	**$70**

EXCLUSIONS AND LIMITATIONS

The Exclusions and Limitations section of the **Certificate** 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) or for which an equivalent over-the-counter product in strength, is available even when a prescription is written, unless otherwise covered by **HMO**.
2. Any drug determined not to be **Medically Necessary** for the treatment of disease or injury unless otherwise covered under this rider.
3. Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by **HMO**.
4. Cosmetic or any drugs used for cosmetic purposes or to promote hair growth, including but not limited to health and beauty aids.
5. Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps.
6. Needles and syringes, other than diabetic needles and syringes.
7. Any medication which is consumed or administered at the place where it is dispensed, or while a **Member** is in a **Hospital**, or similar facility; or take home prescriptions dispensed from a **Hospital** pharmacy upon discharge, unless the pharmacy is a **Participating Retail Pharmacy**.
8. 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.
9. Drugs used for the purpose of weight reduction (e.g., appetite suppressants), including the treatment of obesity.
10. Any refill in excess of the amount specified by the prescription order. Before recognizing charges, **HMO** may require a new prescription or evidence as to need, if a prescription or refill appears excessive under accepted medical practice standards.

11. 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.
12. 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, or any drug labeled "Caution: Limited by Federal Law to Investigational Use", or experimental drugs except as otherwise covered under this rider.
13. Drugs prescribed for cancer treatments that have been determined by the FDA to be contraindicated for the treatment of the specific type of cancer or not approved for any form of cancer or disease, or if the drug is classified as experimental or investigational.
14. Medical supplies, devices and equipment and non-medical supplies or substances regardless of their intended use.
15. Test agents and devices, other than diabetic test agents.
16. Injectable drugs used for the purpose of treating **Infertility**, unless otherwise covered by **HMO**.
17. Injectable drugs, except for insulin.
18. Oral and implantable contraceptives and contraceptive devices, unless otherwise covered under this rider.
19. Prescription orders filled prior to the effective date or after the termination date of the coverage provided by this rider.
20. Replacement for lost or stolen prescriptions.
21. Performance, athletic performance or lifestyle enhancement drugs and supplies.
22. Drugs and supplies when not indicated or prescribed for a medical condition as determined by **HMO** or otherwise specifically covered under this rider or the medical plan.
23. 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.
24. Medication packaged in unit dose form. (Except those products approved for payment by **HMO)**.
25. Prophylactic drugs for travel.
26. Drugs recently approved by the FDA, but which have not yet been reviewed by the Aetna Health Inc. Pharmacy Management Department and Therapeutics Committee.
27. Drugs for the convenience of **Members** or for preventive purposes.
28. Drugs listed on the **Formulary Exclusions List** unless otherwise covered through a medical exception as described in this rider or unless otherwise covered under this rider.
29. Sildenafil citrate, phentolamine, apomorphine and alprostadil in oral, injectable and topical (including but not limited to gels, creams, ointments and patches) forms or any other form used internally or externally. Any prescription drug in oral, topical or any other form that is in a similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes unless otherwise covered under this rider.
30. Nutritional supplements.
31. Smoking cessation aids or drugs.
32. Growth hormones.
33. Drugs or medications in a **Therapeutic Drug Class** if one of the drugs or medications in that **Therapeutic Drug Class** is available over-the-counter (OTC).

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. 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. A **Member** who fails to verify coverage by presenting the ID card will not be entitled to

direct reimbursement from **HMO**, and **Member** will be responsible for the entire cost of the prescription. Refer to the **Certificate** for a description of emergency and **Urgent Care** coverage. **HMO** will not reimburse **Members** for out-of-pocket expenses for prescriptions purchased from a **Participating Retail Pharmacy; Participating Mail Order Pharmacy** or a non-**Participating Retail** or **Mail Order Pharmacy** in non-emergency, non-**Urgent Care** situations. **HMO** retains the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to the Grievance Procedure section of the **Certificate**.

3. **Member** will be charged the **Non-Formulary Prescription Drug Copayment** for prescription drugs covered on an exception basis.

4. The Continuation and Conversion section of the **Certificate,** if any, is hereby amended to include the following provision: the conversion privilege does not apply to the **HMO** Prescription Plan.

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 INC.
(ILLINOIS)

AMENDMENT TO THE PRESCRIPTION PLAN RIDER

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. Prescription Plan Rider is hereby amended as follows:

The Definition of "**Contracted Rate**", appearing in the Definitions section of the Prescription Drug Rider is hereby deleted and, all references to "**Contracted Rate**" are replaced by "**Negotiated Charge**" and the following definition is added to the Definitions section of the Prescription Drug Rider:

- **Negotiated Charge.** The compensation amount negotiated between **HMO** or an affiliate and a **Participating Retail Pharmacy**, **Participating Mail Order Pharmacy**, or **Specialty Pharmacy Network** pharmacy for **Medically Necessary** outpatient prescription drugs and insulin dispensed to a **Member** and covered under the **Member's** benefit plan. This negotiated compensation amount does not reflect or include any amount **HMO** or an affiliate may receive under a rebate arrangement between **HMO** or an affiliate and a drug manufacturer for any drug, including drugs on the **Drug Formulary**.

The Definitions section of the Prescription Plan Rider is amended to add the following:

- **Self-injectable Drug(s)**. Prescription drugs that are intended to be self administered by injection to a specific part of the body to treat certain chronic medical conditions. An updated copy of the list of covered **Self-injectable Drugs**, designated by **HMO** as eligible for coverage under this amendment, shall be available upon request by the **Member** or may be accessed at the **HMO** website, at www.aetna.com. The list is subject to change by **HMO** or an affiliate.

- **Specialty Pharmacy Network**. A network of **Participating** pharmacies designated to fill **Self-injectable Drug** prescriptions.

The Additional Benefits section of the Prescription Plan Rider is amended to include the following benefits:

- **Self-injectable Drugs.**

  Self-injectable Drugs, eligible for coverage under this amendment, are covered when prescribed by a **Provider** licensed to prescribe federal legend prescription drugs or medicines. The prescription must be filled at a **Participating Retail Pharmacy, Participating Mail Order Pharmacy** or **Specialty Pharmacy Network** pharmacy. Coverage of **Self-injectable Drugs** may be subject to the **Precertification Program**, the **Step Therapy Program** or other **HMO** requirements or limitations.

  Food and Drug Administration (FDA) approved **Self-injectable Drugs**, eligible for coverage under this amendment, 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), or 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. Coverage of off-label use of these drugs may be subject to the **Precertification Program**, the **Step Therapy Program** or other **HMO** requirements or limitations.

  Member is responsible for the payment of the applicable **Copayment** for each prescription or refill. The **Copayment** is specified in the Prescription Plan Rider.

The exclusion for Injectable drugs, except for insulin in the Exclusions and Limitations section of the Prescription Plan Rider is hereby deleted and replaced with the following:

- Injectable drugs, except for insulin and **Self-injectable Drugs**.

Coverage is subject to the terms and conditions of the **Certificate.**

AETNA HEALTH INC.
(ILLINOIS)

AMENDMENT TO THE PRESCRIPTION PLAN RIDER
BREAST CANCER PAIN MEDICATION/THERAPY

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. **(HMO) Group Prescription Plan Rider** is hereby amended as follows:

1. The Definitions section is hereby amended to include the following definition:

   - **Pain Therapy.** Medically based therapy and includes reasonably defined goals, including, but not limited to, stabilizing or reducing pain, with periodic evaluations of the efficacy of the pain therapy against these goals.

2. The Additional Covered Benefits provision of the Covered Benefits section is hereby amended to include the following:

   - **Pain Medication/Therapy.**

     All **Medically Necessary** pain medication and P**ain Therapy**, including acupuncture treatments if referred by a **Physician**, related to the treatment of breast cancer.

AETNA HEALTH INC.
(ILLINOIS)

SCHEDULE OF BENEFITS

Plan Name: CITIZEN OPEN ACCESS 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: 739
Contract Holder Service Areas: IL02

BENEFITS

Benefit	Maximums
Maximum Out-of-Pocket Limit **Does not apply to Prescription Drug Benefits.**	**$3,000 per Member per calendar year** **$7,500 per family per calendar year**
Member must demonstrate the Copayment amounts that have been paid during the year.	
Maximum Benefit	**Unlimited per Member per lifetime**

OUTPATIENT BENEFITS

Benefit	Copayment
Primary Care Physician Services	
Adult Physical Examination including Immunizations	**$0 per visit**
Visits 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 including Immunizations	**$0 per visit**
Office Hours Visits	**$10 per visit**
After-Office Hours and Home Visits	**$15 per visit**
Specialist Physician Services	
Office Visits	**$20 per visit**
Routine Gynecological Exam(s) **1 visit(s) per 365 day period**	
Performed at a Primary Care Physician Office	**$0 per visit**
Performed at a Specialist Office	**$0 per visit**

Prenatal Visit(s) by the attending Obstetrician	**$0 per visit**
Outpatient Rehabilitation **60 visits combined for all outpatient rehabilitation therapies per calendar year**	**$20 per visit**
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 Health Visits **Serious Mental Illness** **Unlimited visits per calendar year**	**$20 per visit**
Non-Serious Mental Illness **Unlimited visits per calendar year**	**$10 per visit**
Outpatient Substance Abuse Visits **Detoxification**	**$10 per visit/day**
Outpatient Substance Abuse Visits **Rehabilitation** **Unlimited visits per calendar year**	**$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	**$0 per visit**
Injectable Medications	**$10 per visit or per prescription or refill**

INPATIENT BENEFITS

Benefit	Copayment
Acute Care	**$100 per admission**
Mental Health	
Serious Mental Illness	
Maximum of Unlimited days per calendar year	**$100 per admission**
Non-Serious Mental Illness	
Maximum of Unlimited days per calendar year	**$100 per admission**
Substance Abuse	
Detoxification	**$100 per admission**
Substance Abuse	
Rehabilitation	
Maximum of Unlimited days per 365 day period	**$100 per admission**
Maternity	**$100 per admission**
Skilled Nursing Facility	
Maximum of 60 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)**
Transplant	
Transplant Facility Expense Services	
Inpatient Care	**$100 per admission**

ADDITIONAL BENEFITS

Benefit	Copayment
Eye Examination by a Specialist (including refraction) as per schedule in the Certificate	**$20 per visit**
Subluxation, Chiropractic Benefits	**$20 per visit**
Durable Medical Equipment (DME)	**50% (of the cost) per item**
DME Maximum Benefit	**Unlimited per Member per calendar year**

In no event shall any Copayment exceed 50% of the reasonable cost to HMO for providing the service.

No Copayments shall be required for testing, examinations, and treatment of injuries and trauma sustained by a Member who is a victim of sexual assault or abuse.

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 Certificate 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 mental or physical incapacity, either of which commenced prior to: 26, or if a student, 26.**

Termination of Coverage: **Coverage of the Subscriber and the Subscriber's dependents who are Members, if any, will terminate on the earlier of the date the Group Agreement terminates or 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 INFORMATION

Some language changes in response to the federal Patient Protection and Affordable Care Act (PPACA) may not be included in the enclosed certificate 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 PPACA.

The following is a summary of the requirements under PPACA.

1. For non-grandfathered plans:

   a. Subject to any applicable age, family history and frequency guidelines, the following preventive services, to the extent they are not already, are covered under the plan. Preventive services will be paid at 100% per visit and without cost-sharing such as payment percentages; copays; deductibles; and dollar maximum benefits:
      - Items or services with an "A" or "B" rating from the United States Preventive Services Task Force;
      - Immunizations pursuant to the Advisory Committee on Immunization Practices ("ACIP") recommendations; and
      - Preventive care and screenings that are provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA").

   b. If the plan requires or recommends that you designate a primary care provider, you may select any participating primary care provider who is available to accept you. In addition, you may select any participating pediatrician as your child's primary care provider, if the provider is available to accept your child.

   c. If your plan requires the referral or authorization from the primary care provider before receiving obstetrical or gynecological care from a participating provider who specializes in obstetrics or gynecological care, this requirement no longer applies. Care includes the ordering of related obstetrical and gynecological items and services that are covered under your plan.

   d. You do not need prior authorization for the treatment of an emergency medical condition, even if the services are provided by a non-participating provider. Care provided by a non-participating provider will be paid at no greater cost to you than if the services were performed by a participating provider. You may receive a bill for the difference between the amount billed by the provider and the amount paid by Aetna. If a non-participating provider bills you directly for an amount beyond your cost-share for the treatment of an emergency medical condition, you are not responsible for paying that amount. Please send the bill at the address listed on the back of your member ID card and we will resolve any payment dispute with the provider over the amount. Make sure your member ID number is on the bill.

   e. You have the right to appeal any action taken by Aetna to deny, reduce or terminate the provision or payment of health care services. When we have done this based on the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the service, you have the right to have the decision reviewed by an external review organization.

2. For grandfathered and non-grandfathered plans:

   a. Any overall plan calendar year and lifetime dollar maximums no longer apply.

   b. Any calendar year or annual and lifetime dollar maximum benefit that applies to an "Essential Service" (as required by PPACA and defined by Aetna) for Preferred Care and Non-Preferred Care no longer applies. Essential Services will continue to be subject to any coinsurance; copays; deductibles; other types of maximums (e.g., day and visit maximums); referral and certification

rules; and any exclusions and limitations that apply to these types of covered medical expenses under your plan.

c. If your Plan includes a pre-existing condition limitation provision, including one that may apply to transplant coverage, then this provision will not apply to a person under 19 years of age.

d. The eligibility rules for children 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 solely dependent upon you for support will not apply. **Please Note**: For grandfathered plans only, if your child (under age 26) is eligible for employer based coverage other than through a parent's plan, then that child may not be eligible to enroll in this Plan. Contact your policyholder for further information.

e. If your coverage under the Policy is rescinded, Aetna will provide you with a 30-day advance written notice prior to the date of the rescission.

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.