AETNA HEALTH INC.
(ARIZONA)

GROUP AGREEMENT COVER SHEET

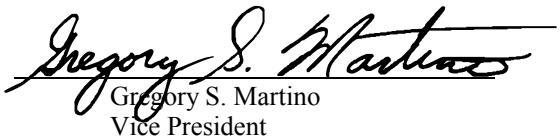
Contract Holder:	The Government of the District of Columbia
Contract Holder Number:	172614 639
HMO Referred Benefit Level:	CITIZEN OPEN ACCESS PLAN Benefits Package
Effective Date:	12:01 a.m. on January 1, 2013
Term of **Group Agreement**:	The **Initial Term** shall be: From January 1, 2013 through December 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 Arizona

Notice Address for **HMO**:

Employer Services Contract Coordinator
1385 E. Shaw
Fresno, CA 93710

The signature below is evidence of Aetna Health Inc.'s acceptance of the **Contract Holder's** Group Application on the terms hereof and constitutes execution of the **Group Agreement(s)** attached hereto on behalf of Aetna Health 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: 639
Contract Holder Group Agreement Effective Date: January 1, 2013

AETNA HEALTH INC.
(ARIZONA)

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 Certificate 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** coverage will terminate as of the last day for which **Premium** was paid. However, if payment is received within the 30 day grace period (the "**Grace Period"),** following the date premium was due, coverage may be reinstated for the period for which **Premium** is paid pursuant to section 6.4.

HMO has the option to provide **Covered Benefits** to **Members** during the **Grace Period**. If HMO elects to provide benefits during the **Grace Period**, **Contract Holder** shall be liable for payment of **Premiums** for the **Grace Period**. A late payment charge of 1 ½% of the total amount due per month (or partial month) will be added to the amount due. In the event **HMO** has extended **Covered Benefits** and **Contract Holder** has not paid all **Premiums** and fees, this **Group Agreement** will automatically terminate at the end of the 30 day **Grace Period** and **Contract Holder** will be liable for all monies due.

We may recover from **Contract Holder Our** costs of collecting any unpaid **Premiums** or fees, including 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 any **Premium Due Date** upon 60 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** or in accordance with the late enrollment procedures outlined in the **Certificate**. 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 60 days written notice to **Contract Holder** if **Contract Holder** (i) ceases to meet **Our** requirements for an employer group; (ii) fails to meet a material plan provision related to **Our** contribution or participation requirements applicable to this **Group Agreement** (which contribution and participation requirements are available upon request).

- 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 in the event the Group terminates Coverage or fails to submit a required **Premium**. However, **We** will 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.

In accordance with the **Certificate**, the **Contract Holder** shall provide written notice to **Members** within 60 days prior to the termination of coverage 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.** Effective April 14, 2003, **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 responsible for any health services rendered to their **Member** patients. **We** make no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any **Physician**, **Hospital** or other **Participating Provider**. A **Provider's** participation may be terminated at any time without advance notice to the **Contract Holder** or **Members**, subject to applicable law. **Participating Providers** provide health care diagnosis, treatment and services for **Members**. **We** administer and determine plan benefits.

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

SECTION 9. MISCELLANEOUS

9.1 **Delegation and Subcontracting**. **Contract Holder** acknowledges and agrees that **We** may enter into arrangements with third parties to delegate functions hereunder such as utilization management, quality assurance and provider credentialing, as **We** deem appropriate in **Our** sole discretion and as consistent with applicable laws and regulations. **Contract Holder** also acknowledges that **Our** arrangements with third party vendors (i.e., pharmacy, behavioral health) are subject to change in accordance with applicable laws and regulations.

9.2 **Accreditation and Qualification Status**. **We** may from time to time obtain voluntary accreditation or qualification status from a private accreditation organization or government agency. **We** make no express or implied warranty about **Our** continued qualification or accreditation status.

9.3 **Prior Agreements; Severability**. As of the **Effective Date**, this **Group Agreement** replaces and supersedes all other prior agreements between the **Parties** as well as any other prior written or oral understandings, negotiations, discussions or arrangements between the **Parties** related to matters covered by this **Group Agreement** or the documents incorporated herein. If any provision of this **Group Agreement** is deemed to be invalid or illegal, that provision shall be fully severable and the remaining provisions of this **Group Agreement** shall continue in full force and effect.

9.4 **Amendments.** This **Group Agreement** may be amended as follows:

- This **Group Agreement** shall be deemed to be automatically amended to conform with all rules and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over **Us**;
- By written agreement between both **Parties**; or
- By **Us** upon 30 days written notice to **Contract Holder**.

The **Parties** agree that an amendment does not require the consent of any employee, **Member** or other person. Except for automatic amendments to comply with law, all amendments to this **Group Agreement** must be approved and executed by **Us**. No other individual has the authority to modify this **Group Agreement**; waive any of its provisions, conditions, or restrictions; extend the time for making a payment; or bind **Us** by making any other commitment or representation or by giving or receiving any information.

9.5 **Clerical Errors**. Clerical errors or delays by **Us** in keeping or reporting data relative to coverage will not reduce or invalidate a **Member's** coverage. Upon discovery of an error or delay, an adjustment of **Premiums** shall be made. **We** may also modify or replace a **Group Agreement**, **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 **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.
(ARIZONA)

AMENDMENT TO THE GROUP AGREEMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Records section of the "Responsibilities of the Contract Holder" section of the **Group Agreement** is hereby amended to include the following:

> **Contract Holder** represents that all enrollment and eligibility information that has been or will be supplied to **Us** is accurate. **Contract Holder** acknowledges that **We** can and will rely on such enrollment and eligibility information in determining whether an individual is eligible for **Covered Benefits** under this **Group Agreement**. To the extent such information is supplied to **Us** electronically, **Contract Holder** agrees to:
>
> - Maintain a reasonably complete record of such information (in electronic or hard copy format, including evidence of coverage elections, evidence of eligibility, changes to such elections and terminations) for at least seven years, and to make such information available to **Us** upon request.
>
> - Obtain from all **Subscribers** a "Disclosure of Healthcare Information" authorization in the form currently being used by **Us** in the enrollment process (or such other form as **We** may reasonably approve).

AETNA HEALTH INC.
(ARIZONA)

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.
(ARIZONA)

CERTIFICATE OF COVERAGE

This Certificate 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 Arizona.

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.

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

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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.

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.

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 **PCP** will notify the **Member** that such recommended treatment is not considered a **Covered Benefit** and that 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**.

D. **Changing a PCP.**

A **Member** may change their **PCP** 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.

E. **Ongoing Reviews.**

HMO conducts ongoing reviews of those services and supplies which are recommended or provided by **Health Professionals** to determine whether such services and supplies are **Covered Benefits** under this **Certificate**. If **HMO** determines that the recommended services and supplies are not **Covered Benefits**, the **Member** will be notified. If a **Member** wishes to appeal such determination, the **Member** may then contact **HMO** to seek a review of the determination. Please refer to the Claim Determination Procedures/Complaints And Appeals/External Independent Medical Review/Dispute Resolution section of this **Certificate**.

F. **Pre-authorization.**

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

G. **Continuity of Care.**

For new **Members** of **HMO**, coverage will be provided for new **Members** to continue an active, ongoing course of treatment with the **Member's** current health care **Provider** during a transitional period, upon **Member's** written request to **HMO**, as follows:

1. For a **Member** with a life threatening disease or condition on their effective date, the transitional period is 30 days after the **Member's** effective date of coverage; or

2. For a **Member** who has entered the third trimester of pregnancy on their effective date, the transitional period includes the delivery and any care up to 6 weeks after the delivery that is related to the delivery.

If a **Member's Participating** health care **Provider** stops participating with **HMO** for reasons other than medical incompetence or unprofessional conduct, on written request from the **Member** to **HMO**, **HMO** will continue an active, ongoing course of treatment with that **Participating** health care **Provider** during a transitional period after the date of the **Provider's** termination, as follows:

1. For a **Member** with a life threatening disease or condition, the transitional period is 30 days after the date of the **Participating Provider's** termination date; or

2. For a **Member** who has entered the third trimester of pregnancy on the **Participating Provider's** termination date, the transitional period includes the delivery and any care up to six weeks after the delivery that is related to the delivery.

HMO will authorize the coverage for the transitional period only if the health care **Provider** agrees to the following in writing:

1. to accept **HMO's** normal reimbursement rates for similar services;

2. to adhere to **HMO's** quality standards and to provide medical information related to such care; and

3. to adhere to **HMO's** policies and procedures.

This provision shall not be construed to require **HMO** to provide coverage for benefits not otherwise covered under this **HMO 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**; and

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

2. To be eligible to enroll as a **Covered Dependent**, the **Contract Holder** must provide dependent coverage for **Subscribers**, and the dependent must be:

   a. the legal spouse 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.

   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. If coverage does not require the payment of an additional **Premium** for a **Covered Dependent**, the **Subscriber** should still enroll the child within 31 days after the date of birth.

      The coverage for newly born, adopted children, and children placed for adoption consists of coverage of injury and sickness, including the necessary care and treatment of

congenital defects and birth abnormalities, and within the limits of this **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. To continue coverage beyond this initial period, the child must be enrolled in **HMO** within the initial 31-day period. If coverage does not require the payment of an additional **Premium** for a **Covered Dependent**, the **Subscriber** should still enroll the child within 31 days after the date of birth.

The initial coverage will not be affected by any provision in this **Certificate** which limits coverage as to a preexisting condition.

HMO shall not be liable for expenses incurred by such child for services or supplies rendered or received prior to the date the child is placed in the **Subscriber's** physical custody, except that:

i. Coverage for a legally adopted child or for a child who has been placed for adoption with the **Subscriber** will include expenses incurred for services and supplies related to the cost of such child's birth, if:

a. the child is adopted within one year of birth; and

b. the **Subscriber** is legally obligated to pay and the costs of the child's birth; and

c. all preexisting conditions, eligibility requirements and other limitations under the **Certificate** have been met and all copayments have been paid by the **Subscriber**; and

d. the **Subscriber** has notified **HMO** of his or her acceptability to adopt children pursuant to Arizona law regarding adoption (§8-105), within 60 days after such acceptance or within 60 days after enrolling in **HMO**; whichever occurs last.

ii. **HMO** Coverage shall be secondary to and in excess of any other maternity benefits coverage of the natural mother. The **Subscriber** must notify **HMO** regarding the existence and extent of any other such coverage of the natural mother.

Within 31 days of **HMO's** request, the **Subscriber** shall provide evidence satisfactory to **HMO** that the child meets any of the above requirements.

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.

The initial coverage will not be affected by any provision in this **Certificate** which limits coverage as to a preexisting condition.

b. Handicapped Children.

Coverage is available for a child who is chiefly dependent upon the **Subscriber** for support and maintenance, and who is 19 years of age or older but incapable of self-support due to 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.

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 change of address, change of **Covered Dependent** status, and enrollment in Medicare or any other group health plan of any **Member**. Additionally, if requested, a **Subscriber** must provide to **HMO**, within 31 days of the date of the request, evidence satisfactory to **HMO** that a dependent meets the eligibility requirements described in this **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 any eligible dependents may be enrolled during a special enrollment period, if requirements (a), (b), (c), (d) and (e) 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.

e. the eligible individual or eligible dependent who is not considered to be a late enrollee, as described in the late Enrollment section of this Certificate, enrolls as described in the Late Enrollment section of this Certificate.

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 any late enrollment provision, 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 any late enrollment provision, if any, described in this **Certificate**.

7. Late Enrollment.

Eligible individuals and their dependents may also be enrolled at any other time upon submission of complete enrollment information and payment of **Premium** to **HMO**. Coverage shall not become effective until confirmed by **HMO**. "Late Enrollee" means an employee or dependent who requests enrollment in **HMO** after the initial enrollment period. An employee or dependent shall not be considered a late enrollee if:

a. the individual:

i. at the time of the initial enrollment period, was covered under a public or private health insurance policy or any other health benefits plan;

ii. lost coverage under a public or private health insurance policy or any other health benefits plan due to the employee's termination of employment or eligibility, the reduction in the number of hours of employment, the termination of the other plan's coverage, the death of the spouse, legal separation, or divorce; or the termination of employer contributions toward coverage, or

iii. requests enrollment within 31 days after the termination of creditable coverage that is provided under a public or private health insurance or other health benefits plan; or

iv. requests enrollment within 31 days after the date of marriage.

b. the individual is employed by an employer that offers multiple health benefits plans, and the individual elects a different plan during an **Open Enrollment Period**; or

c. a court orders a **Subscriber** to provide coverage for a spouse or minor child, and the **Subscriber** requests enrollment within 31 days after the court order is issued.

d. an individual becomes a dependent of a **Subscriber** through marriage, birth, adoption or placement for adoption and the **Subscriber** requests enrollment no later than 31 days after becoming a dependent.

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. **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**.

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** may determine 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**;

- 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.

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 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;

   f. routine vision screenings.

   Periodic health evaluations will be provided when **Medically Necessary** or at least as often as shown below:

Member's Age	Exam Frequency
0 - 1 year	1 exam every 4 months
2 - 5 years	1 exam every year
6 - 40 years	1 exam every 5 years
41 - 50 years	1 exam every 3 years
51 - 60 years	1 exam every 2 years
61 years and over	1 exam every year

Additionally, a medical history and health examination will be offered to each new **Member** within 12 months after enrollment.

6. Injections, including allergy desensitization injections.

7. Casts and dressings.

8. Health Education Counseling and Information.

B. **Diagnostic Services Benefits.**

Services include 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 to a **Participating Provider**, prior to receiving this benefit.

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

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

C. **Specialist Physician Benefits.**

Covered Benefits include outpatient and inpatient services.

When the **Member's** disease/condition is life threatening, degenerative, chronic or disabling and the **Member's PCP** believes the **Member** will need ongoing medical care for an extended period of time to treat that disease/condition, the **Member** may receive a standing **Referral** to such **Specialist**. If **PCP** in consultation with an appropriate **Specialist** determines that a standing **Referral** is warranted, the **PCP** shall make the **Referral** to a **Specialist**. Under this standing **Referral**, **HMO** will authorize the Specialist to provide care to the **Member**. This standing **Referral** shall be pursuant to a treatment plan approved by the **HMO** Medical Director in consultation with the **PCP**, **Specialist** and **Member**.

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**.

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.
- Routine Eye Examinations, including refraction, as follows:

1. if the **Member** is age 1 through 18 and wears eyeglasses or contact lenses, 1 exam(s) every 12-month period.

2. if the **Member** is age 19 and over and wears eyeglasses or contact lenses, 1 exam(s) every 24-month period.

3. if the **Member** is age 1 through 45 and does not wear eyeglasses or contact lenses, 1 exam(s) every 36-month period.

4. if the **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 pre-natal and postpartum care and obstetrical services provided by **Participating Providers** are a **Covered Benefit**.

Coverage does not include routine maternity care (including delivery) received while outside the S**ervice Area** unless the **Member** receives pre-authorization from **HMO**. 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 one home health care visit scheduled to occur within 24 hours of discharge. An additional visit will be covered when prescribed by the **Participating Provider**. This benefit is in addition to the home health maximum number of visits, if any, shown on the Schedule of Benefits. A **Copayment** will not apply for home health care visits.

Coverage for a legally adopted child or for a child who has been placed for adoption with the **Subscriber** will include expenses incurred for services and supplies related to the cost of such child's birth, if:

1. the child is adopted within one year of birth; and

2. the **Subscriber** is legally obligated to pay the costs of the child's birth; and

3. all preexisting conditions, eligibility requirements and other limitations under the **Certificate** have been met and all copayments have been paid by the **Subscriber**; and

4. the **Subscriber** has notified **HMO** of his or her acceptability to adopt children pursuant to Arizona law regarding adoption (§8-105), within 60 days after such acceptance or within 60 days after enrolling in **HMO**; whichever occurs last.

HMO Coverage shall be secondary to and in excess of any other maternity benefits coverage of the natural mother. The **Subscriber** must notify **HMO** regarding the existence and extent of any other such coverage of the natural mother.

Within 31 days of **HMO's** request, the **Subscriber** shall provide evidence satisfactory to **HMO** that the child meets any of the above requirements.

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

A **Member** is covered for services only at **Participating Hospitals** and **Participating Skilled Nursing Facilities**. All services, except for normal maternity admissions, initial emergency medical screening examinations and any immediately necessary emergency stabilizing treatment, are subject to pre-authorization by **HMO**. In the event that the **Member** elects to remain in the **Hospital** or **Skilled Nursing Facility** after the date that the **Participating Provider** and/or the **HMO** Medical Director has determined and advised the **Member** that the **Member** no longer meets the criteria for continued inpatient confinement, the **Member** shall be fully responsible for direct payment to the **Hospital** or **Skilled Nursing Facility** for such additional **Hospital**, **Skilled Nursing Facility**, **Physician** and other **Provider** services, and **HMO** shall not be financially responsible for such additional services.

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**.

Transplants which are non-experimental or non-investigational are a **Covered Benefit**. Covered transplants must be ordered by the **Member's PCP** and **Participating Specialist Physician** and pre-authorized by **HMO**'s Medical Director. The transplant must be performed at **Hospitals** specifically approved and designated by **HMO** to perform these procedures. A transplant is non-experimental and non-investigational hereunder when **HMO** has determined, in its sole discretion, that the **Medical Community** has generally accepted the procedure as appropriate treatment for the specific condition of the **Member**. 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 preauthorization by **HMO**.

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.

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.

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**.

4. Requests for a benefit exchange must be initiated by the **Member's Participating Behavioral Health Provider** under the guidelines set forth by the **HMO**. **Member** must utilize all outpatient mental health benefits, if any, available under the **Certificate** and pay all applicable **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**.

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

1. A **Member** is covered for **Emergency Services**. Emergency care shall include those services rendered under unforseen conditions which require hospitalization or services necessary for the repair of accidental injury, relief of acute pain, initial treatment of acute infection, and the amelioration of illness or conditions which, if not immediately diagnosed and treated, would result in extended or permanent physical impairment or loss of life.

   A **Member** is covered for **Emergency Services**, provided the service is a **Covered Benefit**, and **HMO's** medical review determines that the **Member's** symptoms were an emergency. However, initial medical screening and necessary stabilizing treatment for the emergency condition will be covered for the **Member** even if they are not able to contact either their **PCP** or **HMO** prior to receiving treatment. Such initial medical and stabilizing treatment will be subject to any applicable **Copayment** shown in the Schedule of Benefits.

   The **Copayment** for an emergency room visit as described on the Schedule of Benefits will not apply 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**.

Medical transportation is covered during a **Medical Emergency**, including non-emergency transportation when approved by a **Participating Provider**.

2. **Urgent Care**:

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

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

A **Member** is covered for any follow-up care. Follow-up care is any care directly related to the need for **Emergency Services** 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** unless it can be shown that it was not reasonably possible to communicate with the **PCP** within such time. 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**.

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**. 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** 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**. 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 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** including at least two (2) external breast prostheses subsequent to a covered mastectomy. 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.**

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**. 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. **Basic Infertility Services Benefits.**

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

R. **Diabetes Services.**

Medically Necessary Diabetes treatment, as determined by **HMO**, includes:

1. Blood glucose monitors, including those for the legally blind;

2. Test strips;

3. Insulin preparation and glucagon;

4. Insulin cartridges, including those for the legally blind;

5. Drawing devices and monitors for the visually impaired;

6. Injection aids;

7. Syringes and lancets, including automatic lancing devices;

8. Podiatric appliances for the prevention of complications associated with Diabetes, to the extent such coverage is required under Medicare;

9. Prescribed oral agents for controlling blood sugar; and

10. Any other device, medication, equipment or supply for which coverage is required under Medicare after January 1, 1999. Such coverage is effective within six (6) months after it is required by Medicare.

S. **Blood and Blood Plasma.**

Coverage includes blood; blood plasma; related blood products; administration; processing of blood; processing fees; and fees related to autologous blood donations. Coverage is provided for inpatient general **Hospital** care while a **Member** is confined as an inpatient in a **Hospital** or when provided for emergency care.

T. **Reconstructive Breast Surgery Services.**

Covered services for reconstructive breast surgery resulting from a mastectomy, include:

1. reconstruction of the breast on which the mastectomy is performed, including areolar reconstruction and the insertion of a breast implant;

2. surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed; and

3. **Medically Necessary** physical therapy to treat the complications of the mastectomy, including lymphedema.

U. **Chiropractic 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 **Copayment,** a annual maximum out-of-pocket limit, and a annual maximum benefit may apply to this service. Refer to the Schedule of Benefits attached to this **Certificate**.

V. **Additional Benefits.**

- **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**.

  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**. Replacement, repairs and maintenance are covered only if it is demonstrated to the **HMO** that:

  1. it is needed due to a change in the **Member's** physical condition; or

  2. it is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment.

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

  A **Copayment**, a annual maximum out-of-pocket limit, and a 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**.

- Blood and blood plasma, including 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 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 surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty, except when determined to be **Medically Necessary** by an **HMO** Medical Director, 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 cleft lip and cleft palate including post-mastectomy reconstruction.

- 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 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**, unless pre-authorized by **HMO**.

This exclusion will not apply with respect to drugs:

1. that have been granted treatment investigational new drug (IND) or Group c/treatment IND status;

2. that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or

3. **HMO** has determined that available scientific evidence demonstrates that the drug is effective or the drug shows promise of being effective for the disease.

This exclusion will also not apply to the following:

HMO will provide coverage for all **Medically Necessary** routine patient care costs incurred as a result of a treatment being provided in accordance with a cancer clinical trial in which a **Member** participates voluntarily, except to the extent that the expenses are paid by the government, biotechnical, pharmaceutical or medical device industry sources.

All of the following apply to a course of treatment for a cancer clinical trial:

1. The treatment is part of a scientific study of a new therapy or intervention that is being conducted at an institution in Arizona for the treatment, palliation or prevention of cancer in humans;

2. The treatment is provided as part of a study being conducted in a phase I, phase II, phase III or phase IV cancer clinical trial;

3. The treatment is provided as part of a study being conducted in accordance with a clinical trial approved by at least one of the following:

    a) One of the National Institutes of Health;
    b) An NIH cooperative group or center;
    c) The United States FDA in the form of an investigational new drug application;
    d) The United States Departments of Defense and Veterans Affairs;
    e) A panel of qualified recognized experts in clinical research within academic health institutions in Arizona; or
    f) A qualified research entity that meets the criteria established by the NIH for grant eligibility.

4. The proposed treatment or study has been reviewed and approved by an institutional review board of an institution in Arizona;

5. The personnel providing the treatment or conducting the study are doing so within their scope of practice, experience and training and are capable of providing the treatment because of their experience, training and volume of patients treated to maintain expertise;

6. There is no clearly superior, noninvestigational treatment alternative; and

7. The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as any noninvestigational alternative.

- Hair analysis.

- Hearing aids.

- Home births.

- Home uterine activity monitoring.

- Household equipment, including 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**.

- Implantable drugs.

- The treatment of male or female **Infertility** including:

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

    2. The purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers;

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

    4. Home ovulation prediction kits;

    5. Injectable **Infertility** medications, including menotropins, hCG, GnRH agonists, and IVIG;

    6. Artificial Insemination, in vitro fertilization (IVF), gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), and intracytoplasmic sperm injection (ICSI), and any other advanced reproductive technology ("ART") procedures or services related to such procedures;

    7. Any charges associated with care required for ART (e.g., office, **Hospital**, ultrasounds, laboratory tests, etc.);

    8. Donor egg retrieval or fees associated with donor egg programs, including fees for laboratory tests;

    9. Any charges associated with a frozen embryo transfer, including thawing charges;

    10. Reversal of sterilization surgery; and

    11. Any charges associated with obtaining sperm for any ART procedures.

- 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 those services and supplies:

1. which are not **Medically Necessary**, as determined by **HMO**, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services;

2. that do not require the technical skills of a medical, mental health or a dental professional;

3. furnished mainly for the personal comfort or convenience of the **Member**, or any person who cares for the **Member**, or any person who is part of the **Member's** family, or any **Provider**;

4. furnished solely because the **Member** is an inpatient on any day in which the **Member's** disease or injury could safely and adequately be diagnosed or treated while not confined;

5. furnished solely because of the setting if the service or supply could safely and adequately be furnished in a **Physician's** or a dentist's office or other less costly setting.

- Orthotics except when applied to Diabetes-related care, supplies and treatment.

- Outpatient supplies, including outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings, and reagent strips. This exclusion does not apply to Diabetes-related care, supplies and treatment.

- 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 when applied to Diabetes-related care, supplies and treatment.

- Private duty or special nursing care, unless pre-authorized by **HMO**.

- 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 physical examinations and immunizations, except when **Medically Necessary** or indicated, and diagnostic procedures, in connection with:

    1. obtaining or continuing employment;

    2. securing insurance coverage; or

    3. 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 skin titration (wrinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.

- Specific injectable drugs, except when applied to Diabetes-related care, supplies and treatment, 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 the treatment of **Infertility**, contraception, and performance enhancing steroids.

- Special medical reports, including those not directly related to treatment of the **Member**, e.g., employment or insurance physicals, and reports prepared in connection with litigation.

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

- Therapy or rehabilitation, including 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**. 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 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 sole judgment of **HMO** are equivalent in quality of care, **HMO** reserves the right to provide coverage only for the least costly **Medical Service**, as determined by **HMO**, provided that **HMO** 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,** subject to the terms of this **Certificate**.

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.

C. **Termination For Cause.**

HMO may terminate coverage for cause upon 60 days written notice:

1. if the **Member** has failed to make any required **Premium** 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**.

2. upon discovering a material misrepresentation by the **Contract Holder** in applying for or obtaining coverage or benefits under this **Certificate** or discovering that the **Contract Holder** has committed fraud against **HMO**.

A **Member** may register a **Complaint** with **HMO**, as described in the Claim Determination Procedures/Complaints and Appeals/External Independent Medical Review/Dispute Resolution section of this **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 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** Claim Determination Procedures/Complaints and Appeals/External Independent Medical Review/Dispute Resolution section 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 this **Certificate**.

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

The **HMO** will notify **Members** of the termination of their coverage.

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

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

   Member may elect to continue coverage for 18 months after eligibility for coverage under this **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. **Extension of Benefits While Member is Receiving Inpatient Care.**

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

1. the date of discharge from such inpatient stay;

2. determination by the **HMO** Medical Director in consultation with the attending **Physician**, that care in the **Hospital** or **Skilled Nursing Facility** is no longer **Medically Necessary**;

3. the date the contractual benefit limit has been reached;

4. the date the **Member** becomes covered for similar coverage from another health benefits plan; or

5. 12 months of coverage under this extension of benefits provision.

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

C. **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 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**. A monthly Premium rate shall be offered to the **Member** who is converting to individual coverage and payment of one monthly **Premium** shall be deemed sufficient consideration to enact the conversion coverage. 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 upon loss of coverage due to divorce on the Schedule of Benefits or upon death of the **Subscriber** (subject to the ability of minors to be bound by contract).

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

CLAIM DETERMINATION PROCEDURES/COMPLAINTS AND APPEALS/EXTERNAL INDEPENDENT MEDICAL REVIEW/DISPUTE RESOLUTION

CLAIM DETERMINATION 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.

The HMO will make a decision on the **Member's** claim. For urgent care claims and pre-service claims, the HMO will send the **Member** written notification of the determination, whether adverse or not adverse. For 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 the 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. Adverse benefit determinations can be made for one or more of the following reasons:

- **Utilization Review. HMO** determines that the service or supply is not **Medically Necessary** or are **Experimental or Investigational Procedures**;
- **No Coverage. HMO** determines that a service or supply is not covered by the plan. A service or supply is not covered if it is not included in the list of **Covered Benefits**;
- it is excluded from coverage;
- an **HMO** limitation has been reached; or
- **Eligibility. HMO** determines that the **Subscriber** or **Subscriber**'s **Covered Dependents** are not eligible to be covered by the HMO.

Written notice of an adverse benefit determination will be provided to the **Member** 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 **Complaints** and **Appeals** section of this **Certificate** for more information about **Appeals**.

HMO Timeframe for Notification of an Adverse 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
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

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. Otherwise, within 15 calendar days
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 **Appeal**.
Post-Service Claim. A claim for a benefit that is not a pre-service claim.	Within 30 calendar days

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 two levels.

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

A. **Complaints**.

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

B. **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 2 years from the date of the notice.

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

The HMO provides for two levels of **Appeal** of the adverse benefit determination. If the **Member** decides to **Appeal** to the second level, the request must be made in writing within 60 calendar days from the date of the notice to the following address. The following chart summarizes some information about how the **Appeals** are handled for different types of claims.

Name:	Aetna Health Inc.
Title:	Regional Medical Service Complaint and Appeals Unit
Address:	P.O. Box 10169, Van Nuys, CA 91410
Phone:	877-665-6736
Fax:	818-932-6566

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.	1 Business Day or 36 hours from receipt, whichever is less Review provided by **HMO** personnel not involved in making the adverse benefit determination.	Within 36 hours Review provided by **HMO Appeals** Committee.
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.

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.

C. **External Independent Medical Review.**

1. Eligibility

The **Member** may obtain External Independent Medical Review only after the **Member** has sought any **Appeals** through standard Levels One (Informal Reconsideration) and Two (Formal) **Appeal** above or through Expedited Medical Review. The **Member** has 30 days after receipt of written notice from HMO that the **Member's** Formal **Appeal or Expedited Medical Review** has been denied to request External Independent Medical Review. Neither the **Member** nor the **Member's** treating **Participating Provider** is responsible for the cost of any External Independent Medical Review. The **Member** must send a written request for External Independent Medical Review and any material justification or documentation to support the **Member**'s request for the covered service or claim for a covered service to:

Name: Aetna Health Inc.
Title: National External Review Unit
Address: 11675 Great Oaks Way, Alpharetta, GA 30022

Phone: 877-848-5855 (Toll-free number)
Fax: 770-801-7135

2. Process: There are 2 types of External Independent Medical Review **Appeals**, depending on the issues in the **Member's** case:

   a. **Medical Necessity Appeals** are cases where **HMO** has decided not to authorize a service because **HMO** believes the service(s) the **Member** or the **Member's** treating **Participating Provider** are asking for, are not **Medically Necessary** to treat the **Member's** condition. The external independent reviewer is a **Provider** retained by an outside Independent Review Organization ("IRO"), that is procured by the Arizona Insurance Department, and not connected with **HMO**. The IRO **Provider** must be one who typically manages the condition under review.

   Within 5 business days of receiving the **Member's** or the Director of Insurance's request, or if **HMO** initiates an External Independent Medical Review, **HMO** must:

   - Mail a written acknowledgement to the Director of Insurance, the **Member**, and the **Member's** treating **Participating Provider**.

   - Send the Director of Insurance: the request for review; the **Member's HMO Certificate**; all medical records and supporting documentation used to render **HMO's** decision; a summary of the applicable issues including a statement of **HMO's** decision; the criteria used and clinical reasons for **HMO's** decision; and the relevant portions of **HMO's** utilization review guidelines. We must also include the name and credentials of the **Participating Provider** who reviewed and upheld the denial at the earlier **Appeal** levels.

   Within 5 business days of receiving **HMO's** information, the Director of Insurance must send all the submitted information to an expedited, external independent review organization (the "IRO").

   Within 21 business days of receiving the information, the IRO must make a decision and send the decision to the Director of Insurance.

   Within 5 business days of receiving the IRO's decision, the Director of Insurance will mail a notice of the decision to **HMO**, the **Member**, and the **Member's** treating **Participating Provider**.

   b. Contract Coverage issues are **Appeals** where **HMO** has denied coverage because **HMO** believes the requested service is not covered under the **Member's HMO Certificate**. For these **Appeals**, the Arizona Insurance Department is the external independent reviewer.

   Within 5 business days of receiving the **Member's** request or if **HMO** initiates an External Independent Medical Review, **HMO** must:

   - Mail a written acknowledgement of the **Member's** request to the Director of Insurance, the **Member**, and the **Member's** treating **Participating Provider**.

   - Send the Director of Insurance: the request for review, the **Member's HMO Certificate**; all medical records and supporting documentation used to render **HMO's** decision; a summary of the applicable issues including a statement of

HMO's decision, the criteria used and any clinical reasons for our decision and the relevant portions of **HMO's** utilization review guidelines.

Within 15 business days of receiving this information, the Director of Insurance will determine if the service or claim is covered, issue a decision, and send a notice of determination to **HMO**, the **Member**, and the **Member's** treating **Participating Provider**.

The Director of Insurance is sometimes unable to determine issues of coverage. If this occurs or if the Director of Insurance finds that the case involves a medical issue, the Director of Insurance will forward the **Member's** case to an IRO. The IRO will have 21 business days to make a decision and send it to the Director of Insurance. The Director of Insurance will have 5 business days after receiving the IRO's decision to send the decision to **HMO**, the **Member,** and the **Member's** treating **Participating Provider**.

3. Decision

Medical Necessity decision:

If the IRO decides that **HMO** should provide the service, **HMO** must authorize the service regardless of whether judicial review is sought. If the IRO agrees with **HMO's** decision to deny the service, the **Appeal** is over. The **Member's** only further option is to pursue the **Member's** claim in Superior Court. However, on written request by the IRO, the **Member** or **HMO**, the Director of Insurance may extend the 21-day time period for up to an additional 30 days, if the requesting party demonstrates good cause for an extension.

Contract Coverage decision:

If the **Member** disagrees with the Insurance Director's final decision on a contract coverage issue, the **Member** may request a hearing with the Office of Administrative Hearings ("OAH"). If **HMO** disagrees with the Director's final decision, **HMO** may also request a hearing before the OAH. A hearing must be requested within 30 days of receiving the coverage issue determination. OAH has rules that govern the conduct of their hearing proceedings.

Expedited Appeals Process For Urgently Needed Services The Member Has Not Yet Received

A. **Expedited Medical Review (Level One).**

1. Eligibility

The **Member** may obtain Expedited Medical Review of the denied request for a covered service that has not already been provided if:

- The **Member** has coverage with **HMO**.
- **HMO** has denied the **Member's** request for a covered service, and
- The **Member's Physician** or treating **Participating Provider** certifies in writing and provides supporting documentation that the time required to process the **Member's** request through the standard Informal Reconsideration Process described above and standard Formal **Appeal** Process described above is likely to cause a significant negative change in the **Member's** medical condition. This certification is not challengeable by **HMO**.

The **Member's** treating **Participating Provider** must send the certification and documentation to:

Name: Aetna Health Inc.
Title: National External Review Unit
Address: 11675 Great Oaks Way, Alpharetta, GA 30022

Phone: 877-848-5855 (Toll-free number)
Fax: 770-801-7135

2. Decision

HMO has 1 business day after **HMO** receives the information from the **Member's** treating **Participating Provider** to decide whether **HMO** should change their decision and authorize the **Member's** requested service. Within that same business day, **HMO** must mail to the **Member and the Member's treating Participating Provider HMO's** decision in writing. Notice of the decision will include criteria used to make the decision, clinical reasons for the decision, and any references to supporting documentation.

If the **Member's Appeal** is an issue of **Medical Necessity**, before making the decision, **HMO** will consult with a:

Physician or other appropriate licensed health care professional, or

An out-of-state **Provider**, **Physician** or other health care professional who is licensed in another state and who is not licensed in Arizona and who typically manages the **Member's** medical condition under review.

a. Denial Upheld

If **HMO** agrees that the covered service should have been denied, **HMO** will telephone the **Member** and the **Member's** treating **Participating Provider** and will mail to the **Member** and the **Member's** treating **Participating Provider** a notice of the adverse decision and of the **Member's** option to immediately proceed to an Expedited **Appeal** Level Two **Appeal**.

b. Denial Reversed

If **HMO** agrees that the covered service should have been provided, **HMO** must authorize the service and the **Member's Appeal** is ended.

B. **Expedited Appeal (Level Two).**

1. Eligibility

If **HMO** denies a **Member**'s request at Expedited Medical Review Level One for a covered service that has not already been provided, the **Member** may request an Expedited **Appeal**. After the **Member** receives **HMO's** Level One denial, the **Member's** treating **Participating Provider** must immediately send a written request to **HMO** (to the same person and address listed above under Level One for to notify **HMO** that the **Member** is appealing to Level Two **Appeal**. The **Member's** treating **Participating Provider** may want to send any additional information, not previously submitted to **HMO**, to support the **Member's** request for the service.

2. Process

Medically Necessary Appeal decisions will be made by any **Provider** who is qualified in a scope of practice similar to that of the treating **Participating Provider**, or one who typically manages the medical condition under **Appeal**. **HMO** will select the **Provider** who shall review the **Appeal** and render the decision.

Coverage issue **Appeal** decisions are not required to be rendered by a **Participating Provider**.

3. Decision

HMO has 3 business days after receipt of the request for an Expedited **Appeal** Level Two **Appeal**. to notify the **Member** and the **Member's** treating **Participating Provider** of the decision.

a. Denial Upheld

If **HMO** agrees that the covered service should have been denied, the **Member** may immediately **Appeal** to External Independent Medical Review. **HMO** will telephone the **Member** and the **Member's** treating **Participating Provider** and will mail to the **Member** and the **Member's** treating **Participating Provider** a notice of the denial and of the **Member's** option to immediately proceed to Expedited External Independent Review.

b. Denial Reversed

If **HMO** agrees that the covered service should have been provided, **HMO** must authorize the service and the **Member's Appeal** is ended.

c. **HMO** may decide to skip Level Two **Appeal** and send the **Member's** case straight to Expedited External Independent Review. **HMO** must send the **Member** and the **Member's** treating **Participating Provider** a written acknowledgment that the **Appeal** was submitted for Expedited External Independent Medical Review.

C. **Expedited External Independent Medical Review.**

1. Eligibility

The **Member** may **Appeal** to Expedited External Independent Medical Review only after the **Member** has appealed through Level One. The **Member** has 5 business days after the **Member** receives **HMO's** Level One decision to send **HMO** the **Member's** written request for Expedited External Independent Medical Review. The **Member's** request should include any additional information to support the **Member's** request for the service. The **Member** and the **Member's** treating **Participating Provider** are not responsible for the cost of any Expedited External Independent Medical Review.

The **Member** should send the request and any additional supporting information to:

Name: Aetna Health Inc.
Title: National External Review Unit
Address: 11675 Great Oaks Way, Alpharetta, GA 30022

Phone: 877-848-5855 (Toll-free number)
Fax: 770-801-7135

2. Process: There are 2 types of Expedited External Independent Medical Review **Appeals**, depending on the issues in the **Member's** case:

   a. **Medical Necessity Appeals** are cases where **HMO** has decided not to authorize a service because **HMO** believes the service(s) the **Member** or the **Member's** treating **Participating Provider** are asking for, are not **Medically Necessary** to treat the **Member's** condition. The expedited external independent reviewer is a **Provider** retained by an outside independent review organization ("IRO"), that is procured by the Arizona Insurance Department, and not connected with **HMO**. The IRO **Provider** must be a **Provider** who typically manages the condition under review.

   Within 1 business day of receiving the **Member's** request, **HMO** must:

   - Mail a written acknowledgement of the request to the Director of Insurance, the **Member**, and the **Member's** treating **Participating Provider**.

   - Send the Director of Insurance: the request for review; the **Member's HMO Certificate**; all medical records and supporting documentation used to render **HMO's** decision; a summary of the applicable issues including a statement of **HMO's** decision; the criteria used and clinical reasons for **HMO's** decision; and the relevant portions of **HMO's** utilization review guidelines. **HMO** must also include the name and credentials of the **Participating Provider** who reviewed and upheld the denial at the earlier appeal levels.

   Within 2 business days of receiving **HMO's** information, the Director of Insurance must send all the submitted information to an expedited, external independent reviewer organization (the "IRO").

   Within 5 business days of receiving the information, the IRO must make a decision and send the decision to the Insurance Director.

   Within 1 business day of receiving the IRO's decision, the Insurance Director must mail a notice of the decision to **HMO**, the **Member**, and the **Member's** treating **Participating Provider**.

   b. Contract Coverage issues are **Appeals** where **HMO** has denied coverage because **HMO** believes the requested service is not covered under the **Member's HMO Certificate**. For these **Appeals**, the Arizona Insurance Department is the expedited external independent reviewer.

   Within 1 business day of receiving the **Member's** request, **HMO** must:

   - Mail a written acknowledgement of the **Member's** request to the Insurance Director, the **Member**, and the **Member's** treating **Participating Provider**.

   - Send the Director of Insurance: the request for review, the **Member's HMO Certificate**; all medical records and supporting documentation

used to render **HMO's** decision; a summary of the applicable issues including a statement of **HMO's** decision, the criteria used and any clinical reasons for our decision and the relevant portions of **HMO's** utilization review guidelines.

Within 2 business days of receiving this information, the Insurance Director must determine if the service or claim is covered, issue a decision, and send a notice to **HMO**, the **Member**, and the **Member's** treating **Participating Provider**.

The Director of Insurance is sometimes unable to determine issues of coverage. If this occurs, the Director of Insurance will forward the **Member's** case to an IRO. The IRO will have 5 business days to make a decision and send it to the Insurance Director. The Insurance Director will have 1 business day after receiving the IRO's decision to send the decision to **HMO**, the **Member,** and the **Member's** treating **Participating Provider**.

3. Decision

Medical Necessity decision:

If the IRO decides that **HMO** should provide the service, **HMO** must authorize the service. If the IRO agrees with **HMO's** decision to deny the service, the appeal is over. The **Member's** only further option is to pursue the **Member's** claim in Superior Court.

Contract Coverage decision:

If the **Member** disagrees with the Insurance Director's final decision on a contract coverage issue, the **Member** may request a hearing with the Office of Administrative Hearings ("OAH"). If **HMO** disagrees with the Director's final decision, **HMO** may also request a hearing before the OAH. A hearing must be scheduled within 30 days of receiving the Director's decision. OAH must promptly schedule and complete a hearing for **Appeals** from Expedited External Independent Medical Review **Appeals** decisions.

D. **The Role of the Director of Insurance.**

Arizona law (A.R.S. §20-2533(F)) requires "any **Member** who files a **Complaint** or **Appeal** with the Department relating to an adverse decision to pursue the review process prescribed" by law. This means, that for decisions that are appealable, the **Member** must pursue the health care **Appeals** process before the Director or Insurance can investigate a **Complaint** or **Appeal** the **Member** may have against **HMO** based on the decision at issue in the **Appeal**.

The **Appeal** process requires the Director to:

1. Oversee the **Appeals** process.
2. Maintain copies of each utilization review plan submitted by **HMO**.
3. Receive, process, and act on requests from **HMO** for External Independent Medical Review.
4. Enforce the decisions of **HMO**.
5. Review decisions of **HMO**.
6. Report to the Legislature.
7. Send, when necessary, a record of the proceedings of an **Appeal** to Superior Court or to the Office of Administrative Hearings (OAH).
8. Issue a final administrative decision on coverage issues, including the notice of the right to request a hearing at the OAH.

E. **Obtaining Medical Records.**

Arizona law (A.R.S. §12-2293) permits the **Member** to ask for a copy of their medical records. The **Member's** request must be in writing and must specify who the **Member** wants to receive the records. The health care **Provider** who has the **Member's** records will provide the **Member** or the person the **Member** specifies with a copy of the **Member's** records.

Designated Decision-Maker: If the **Member** has a designated health care decision-maker, that person must send a written request for access to or copies of the **Member's** medical records. The medical records must be provided to the **Member's** health care decision-maker or a person designated in writing by the **Member's** health care decision-maker unless the **Member** limits access to the **Member's** medical records only to the **Member** or the **Member's** health care decision-maker.

Confidentiality: Medical records disclosed under A.R.S. §12-2293 remain confidential. If the **Member** participates in the **Appeal** process, the relevant portions of the **Member's** medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose the **Member's** medical information to any other people.

F. **Documentation for an Appeal.**

If the **Member** decides to file an **Appeal**, the **Member** must give us any material justification or documentation for the **Appeal** at the time the **Appeal** is filed. If the **Member** gathers new information during the course of the **Member's Appeal**, the **Member** should give it to us as soon as the **Member** receives it. The **Member** must also give **HMO** the address and phone number where the **Member** can be contacted. If the **Appeal** is already at Expedited External Independent Medical Review, the **Member** should also send the information to the Department.

G. **Receipt of Documents.**

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed (the **Member's** last known address) on the fifth business day after being mailed.

H. **Record Retention.**

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

I. **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**.

DISPUTE RESOLUTION

Any controversy, dispute or claim between **HMO** 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. **HMO** and **Interested Parties** hereby give up their 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 **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.

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 **Deductibles,** 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. This **Plan** limits coordination of healthcare services or expenses with those services or expenses that are covered under similar types of **Plans,** e.g. coordination with Medical/Pharmacy coverage is coordinated with Medical/Pharmacy **Plans**. 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.

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). Usually 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 (except prepaid dental) 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
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 **Plan** includes both medical and dental coverage, those coverages, will be considered separate **Plans**. The Medical/Pharmacy coverage will be coordinated with other Medical/Pharmacy **Plans**. In turn, the dental coverage will be coordinated with other dental **Plans**.

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

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

When coverage under this Certificate of Coverage 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 of Coverage 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 of Coverage 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 of Coverage 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** with an Order of Benefit Determination provision which complies with the Order of Benefit Determination section of this **Certificate** (complying plan), may coordinate its benefits with a **Plan** which is excess or **Secondary Plan** or which uses an Order of Benefit Determination provision which is inconsistent with that contained in the Order of Benefit Determination section of this **Certificate** (noncomplying plan) on the following basis:

1. If the complying plan is the **Primary Plan**, it shall pay or provide its benefits on a primary basis.

2. If the complying plan is the **Secondary Plan**, it shall, nevertheless, pay or provide its benefits first, as the **Secondary Plan**. In such a situation, such payment shall be the limit of the complying plan's liability, except as provided in subparagraph B.4.

3. If the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the noncomplying plan are identical to its own, and shall pay its benefits accordingly. However, the complying plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the noncomplying plan.

4. If the noncomplying plan pays benefits so that the **Member** receives less in benefits than the **Member** would have received had the noncomplying plan paid or provided its benefits as the **Primary Plan** then the complying plan shall advance to or on behalf of the **Member** an amount equal to such difference which advance shall not include a right to reimbursement from the **Member**.

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.

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

   a. The **Primary Plan** is the **Plan** of the parent whose birthday is earlier in the year if:

      - The parents are married;
      - The parents are not separated (whether or not they ever have been married); or
      - A court decree awards joint custody without specifying that 1 party has the responsibility to provide health care coverage.

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

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

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

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

3. **Active or Inactive Employee.** The **Plan** that covers a person as an employee who is neither laid off nor retired, is the **Primary Plan**. 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 **Plans** meeting the definition of **Plan** under this section. In addition, this **Plan** will not pay more than it would have paid had it been primary.

Effect On Benefits Of This Certificate of Coverage.

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 (Not Including Medicaid).

The following provisions explain how the benefits under this Certificate of Coverage 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 of Coverage will pay for such benefits as follows:

If a **Member's** coverage under this Certificate of Coverage is based on current employment with the **Contract Holder**, coverage under this Certificate of Coverage 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 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 employees).

Otherwise, coverage under this Certificate of Coverage will cover the benefits as the **Secondary Plan**. Coverage under this Certificate of Coverage 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 **Subscribers**, the following will also apply:

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

Right to Receive and Release Needed Information.

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits under this **Plan** and other **Plans**. **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 of Coverage. 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 of Coverage. **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.

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**. 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.

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 through their signature on the Enrollment/Change Request Form or any signed authorization used for the purpose of collecting information in connection with a claim for benefits**, 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. **Assignment of Benefits.** All rights of the **Member** to receive benefits hereunder are personal to the **Member** and may not be assigned.

D. **Legal Action.** No action at law or in equity may be maintained against **HMO** for any expense or bill prior to the expiration of 60 days after written submission of claim has been furnished in accordance with requirements set forth in 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.

E. **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 after the date of termination of the Provider Agreement are **Covered Benefits** only if the services or supplies were furnished

during a **Member's** confinement and the confinement began prior to the date of the termination.

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.

F. **Inability to Provide Service.** If due to circumstances not within the reasonable control of **HMO**, including 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.

G. **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. **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.

H. **Limitation on Services.** Except in cases of an **Emergency Service**, Urgent Care, and Emergency/Urgent follow-up care as 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**.

I. **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.

J. 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**.

K. **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. This can also be done by mutual written agreement between **HMO** and **Contract Holder** without the consent of **Members**. However, any and all amendments initiated by **HMO** will be done after 60 days written notice is provided to **Contract Holder**.

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

M. 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.

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

O. 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:

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

- **Certificate.** This **Certificate**, 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.

- **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 60 days written notice to the **Contract Holder** prior to the annual renewal date.

- **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 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 and Fees 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 this **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, and any

health benefit plan under section 5(e) of the Peace Corps 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 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 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**, 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.

- **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**, 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**.

- **Experimental or Investigational Procedures.** Services or supplies that are, as determined by **HMO**, experimental. A drug, device, procedure or treatment will be determined to be experimental if:

    1. there is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or

    2. required FDA approval has not been granted for marketing; or

    3. a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or

    4. the written protocol or protocol(s) used by the treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or

    5. it is not of proven benefit for the specific diagnosis or treatment of a **Member's** particular condition; or

6. it is not generally recognized by the **Medical Community** as effective or appropriate for the specific diagnosis or treatment of a **Member's** particular condition; or

7. it is provided or performed in special settings for research purposes.

- **Group Agreement.** The **Group Agreement** between **HMO** and the **Contract Holder**, including the Group Application, 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 Arizona corporation licensed by the Arizona 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**.

- **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 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** as meeting reasonable standards. A **Hospital** may be a general, acute care, rehabilitation or specialty institution.

- **Infertile** or **Infertility.** The condition of a presumably healthy **Member** who is unable to conceive or produce conception after 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination (for **Members** less than 35 years of age), or 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination (for **Members** 35 years of age or older). **Infertile** or **Infertility** does not include conditions for male **Members** when the cause is a vasectomy or orchiectomy or for female **Members** when the cause is a tubal ligation or hysterectomy with or without surgical reversal.

- **Interested Parties.** Means **Contract Holder** and **Members**, including any and all affiliates, agents, assigns, employees, heirs, personal representatives or subcontractors of an **Interested Party**.

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

- **Medical Emergency.** Services that are provided to a Member in a licensed facility by a Provider after the recent onset of a medical condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonable be expected to result in any of the following:

  a. Serious jeopardy to the Member's health.
  b. Serious impairment to bodily functions.
  c. 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 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 of not less than thirty (30) consecutive working days, 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.

- **Provider(s).** A **Physician**, **Health Professional**, **Hospital**, **Skilled Nursing Facility**, home health agency or other recognized entity or person licensed to provide **Hospital** or **Medical Services** to **Members**.

- **Reasonable Charge.** The charge for a **Covered Benefit** which is determined by the **HMO** to be the prevailing charge level made for the service or supply in the geographic area where it is furnished. **HMO** may take into account factors such as the complexity, degree of skill needed, type or specialty of the **Provider**, range of services provided by a facility, and the prevailing charge in other areas in determining the **Reasonable Charge** for a service or supply that is unusual or is not often provided in the area or is provided by only a small number of providers in the area.

- **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** 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.

AETNA HEALTH INC.
(ARIZONA)

DISCOUNT PROGRAMS CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

The Discount Provision O. appearing in the General Provisions section of the **Certificate** is hereby deleted and replaced with the following:

O. **Additional Provisions**:

1. Discount Arrangements: From time to time, **HMO** may offer, provide, or arrange for discount arrangements or special rates from certain service **Providers** such as pharmacies, optometrists, dentists, alternative medicine, wellness and healthy living providers to **Member**s or persons who become **Member**s. Some of these arrangements may be available through third parties who may make payments to **HMO** in exchange for making these services available. The third party service **Providers** are independent contractors and are solely responsible to **Members** for the provision of any such goods and/or services. **HMO** reserves the right to modify or discontinue such arrangements at any time. These discount arrangements do not constitute benefits provided under the **Group Agreement**. There are no benefits payable to **Member**s nor does **HMO** compensate **Provider**s for services they may render.

2. Incentives: In order to encourage **Members** to access certain medical services when deemed appropriate by the **Member**, in consultation with the **Member's Physician** or other service **Provider**, **HMO** may, from time to time, offer to waive or reduce a **Member's Copayment**, **Coinsurance**, and/or a **Deductible** otherwise required under this **Certificate** or offer coupons or other financial incentives. **HMO** has the right to determine the amount and duration of any waiver, reduction, coupon, or financial incentive and to limit the **Members** to whom these arrangements are available.

AETNA HEALTH INC.
(ARIZONA)

TERMINATION OF COVERAGE
&
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 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 60 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 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** 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 further liability or responsibility under this **Certificate** except for coverage for **Covered Benefits** provided prior to the date of termination of coverage.

   The **HMO** will notify **Members** of the termination of their coverage

3. The Claim Determination Procedures/Complaints and Appeals/External Independent Medical Review/Dispute Resolution sections of the **Certificate**, and any amendments to these sections of the **Certificate** are replaced with the following:

   Help in Filing an Appeal: Standardized Forms and Consumer Assistance from the Department of Insurance

   We must send you a copy of the Health Care Insurer Appeals Process Information Packet when you first receive your policy, and within 5 business days after we receive your request for an appeal. When your insurance coverage is renewed, we must also send you a separate statement to remind you that you can request another copy of the packet. We will also send a copy of the packet to you or your treating provider at any time upon request. To request a copy, just call the **Member** Services number printed on your Member ID Card.

At the back of the packet are forms you can use for your appeal. The Arizona Insurance Department ("the Department") developed these forms to help people who want to file a health care appeal. You are not required to use them. We cannot reject your appeal if you do not use them. If you need help in filing an appeal, or you have questions about the appeals process, you may call the Department's Consumer Assistance Office at 602-364-2499 or 1-800-325-2548 (inside Arizona but outside the Phoenix area), or via the internet at http://www.azinsurance.gov, or you may call us at 1-800-756-7039.

How to Know When You Can Appeal

When we do not authorize or approve a service or pay for a claim, we must notify you of your right to appeal that decision. Your notice may come directly from us, or through your treating provider.

Decisions You Can Appeal

You can appeal the following decisions:

1. We do not approve a service that you or your treating provider has requested.
2. We do not pay for a service that you have already received.
3. We do not authorize a service or pay for a claim because we say that it is not "medically necessary".
4. We do not authorize a service or pay for a claim because we say that it is not covered under your insurance policy, and you believe it is covered.
5. We do not notify you, within 10 business days of receiving your request, whether or not we will authorize a requested service.
6. We do not authorize a referral to a specialist.
7. You disagree with our decision to issue or not issue a policy to you.

Decisions You Cannot Appeal

You cannot appeal the following decisions:

1. You disagree with our decision as to the amount of "usual, customary, and reasonable charges". Where applicable, a usual, customary, and reasonable charge is a charge for a covered benefit which is determined by us to be the prevailing charge level made for the service or supply in the geographic area where it is furnished. We 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 usual, customary, and 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.
2. You disagree with how we are coordinating benefits when you have health insurance with more than one insurer.
3. You disagree with how we have applied your claims or services to your plan deductible.
4. You disagree with the amount of coinsurance or copayments that you paid.
5. You are dissatisfied with any rate increases you may receive under your insurance policy.
6. You believe we have violated any part of the Arizona Insurance Code.

If you disagree with a decision that cannot be appealed according to this list, you may still file a complaint with us by calling our Customer Services Department at the number printed on your Member ID Card. In addition, you may also file such complaints with the Arizona Department of Insurance, Consumer Affairs Division, 2910 N. 44th Street, Second Floor, Phoenix, AZ 85018.

Who Can File an Appeal

Either you or your treating provider can file an appeal on your behalf. At the end of the packet is a form that you may use for filing your appeal. You are not required to use that form. If you wish, you can send us a letter with the same information. If you decide to appeal our decision to deny authorization for a

service, you should tell your treating provider so the provider can help you with the information you need to present your case.

DESCRIPTION OF THE APPEALS PROCESS

I. Levels of Review

We offer expedited as well as standard appeals for Arizona residents. Expedited appeals are for urgently needed services that you have not yet received. Standard appeals are for non-urgent service requests and denied claims for services already provided. Both types of appeals follow a similar process, except that we process expedited appeals much faster because of the patient's condition.

Each type of appeal has three levels, as follows:

Expedited Appeals (For urgently needed services you have not yet received)	**Standard Appeals** (For non-urgent services or denied claims)
Level One: Expedited Medical Review	Informal Reconsideration
Level Two: Expedited Appeal	Formal Appeal
Level Three: Expedited External, Independent Medical Review	External, Independent Medical Review

We make the decisions at Level One and Level Two. An outside reviewer, who is completely independent from our company, makes Level Three decisions. You are not responsible to pay the costs of the external review if you choose to appeal to Level Three. These three levels of Appeals are discussed more fully below:

Before requesting a level three, you must exhaust the internal appeal process unless:
- We waive the exhaustion requirement
- We fail to comply with the requirements of the internal appeal process except failures that are based on de minimis violations
- You request a simultaneous expedited internal and external appeal.

You may supply additional information that you would like us to consider. In addition, you may request copies of documents relevant to your claim (free of charge) by contacting us at the number on your member identification card.

EXPEDITED APPEAL PROCESS FOR URGENTLY NEEDED SERVICES NOT YET PROVIDED

Expedited Medical Review (Level One)

Your Request: You may obtain Expedited Medical Review of your denied request for a service that has not already been provided if:
- You have coverage with us;
- We denied your request for a covered service; and
- Your treating provider certifies that the time required to process your request through the Informal Reconsideration (Level One) and Formal Appeal (Level Two) appeal process (about 30 days) is likely to cause a significant negative change in your medical condition. (At the end of this packet is a form that your provider may use for this purpose. Your provider could also send a letter or make up a form with similar information.) Your treating provider must send the certification and documentation to:

Name: Aetna Health Inc.
Title: Customer Resolution Team
Address: P.O. Box 14002, Lexington, KY 40512

Phone: 1-877-665-6736
Fax: 860-754-5321

Our Decision: We must call and inform you and your treating provider of our decision within **1 business day or 36 hours from request receipt, whichever is less**. We will then mail our decision in writing to both you and your treating provider. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision. You may simultaneously request an internal and external expedited appeal.

If we deny your request: You may immediately appeal to Level Two.

If we grant your request: We will authorize the service and the appeal process is complete.

If we refer your case to Level Three: We may decide to skip Level One and Level Two and send your case straight to an independent reviewer at Level Three.

Expedited Appeal (Level Two)

Your request: If we deny your request at Level One, you may request an Expedited Appeal. After you receive our Level One denial, your treating provider ***must immediately*** send us a request (to the same person and address listed above under Level One) to tell us you are appealing to Level Two. To help your appeal, your provider should also send us any more information that the provider hasn't already sent us to show why you need the requested service.

Our Decision: We must call and inform you and your treating provider of our decision within **1 business day or 36 hours from request receipt, whichever is less**. We will then mail our decision in writing to both you and your treating provider. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request: **You may immediately appeal to Level Three.**

If we grant your request: We will authorize the service and the appeal process is complete.

If we refer your case to Level Three: We may decide to skip Level Two and send your case straight to an independent reviewer at Level Three.

Expedited External, Independent Review (Level Three)

Your request: You may Appeal to an Expedited External Independent Medical Review only after you have appealed through Level Two. You have four months after you receive the Aetna Level Two decision to send Aetna your written request for Expedited External Independent Medical Review. Your request should include any additional information to support your request for the service. Your written request for Expedited External Independent Medical Review should be sent to:

Name: Priscilla Bugari, R.N.
Title: Director, Aetna National External Review Unit
Address: 1100 Abernathy Rd, Suite 375, Atlanta, GA 30328

Phone: 1-877-848-5855 (Toll-free number)
Fax: 860-975-1526

You and your treating Provider are not responsible for the cost of any Expedited External Independent Medical Review.

Process: There are 2 types of Expedited External Independent Medical Review Appeals, depending on the issues in your case:

1. Medical Necessity Appeals are cases where Aetna has decided not to authorize a service because Aetna believes the service(s) you or your treating Provider are asking for, are not Medically Necessary to treat your condition or do not meet criteria for appropriateness, health care setting, level of care, or effectiveness of a covered benefit. The expedited external independent reviewer is a Provider retained by an outside independent review organization ("IRO"), that is procured by the Arizona Department of Insurance, and is not connected with Aetna. The IRO Provider must be a Provider who typically manages the condition under review.

   Within 1 business day of receiving your request, Aetna must:
   - Mail a written acknowledgement of the request to the Director of Insurance, you, and your treating Provider.
   - Send the Director of Insurance: the request for review; your Certificate of Coverage or Group Insurance Certificate; all medical records and supporting documentation used to render Aetna's decision; a summary of the applicable issues including a statement of Aetna's decision; the criteria used and clinical reasons for Aetna's decision; and the relevant portions of Aetna's utilization review guidelines. Aetna must also include the name and credentials of the Provider who reviewed and upheld the denial at the earlier appeal levels.

   Within 2 business days of receiving Aetna's information, the Director of Insurance must send all the submitted information to the external independent reviewer organization (the "IRO").

   Within 72 hours of receiving the information, the IRO must make a decision and send the decision to the Director of Insurance.

   Within 48 hours of receiving the IRO's decision, the Director of Insurance must mail a notice of the decision to Aetna, you and your treating Provider.

2. Contract Coverage issues are Appeals where Aetna has denied coverage because Aetna believes the requested service is not covered under your Certificate of Coverage or Group Insurance Certificate. For these Appeals, the Arizona Department of Insurance is the expedited external independent reviewer.

   Within 1 business day of receiving your request, Aetna must:
   - Mail a written acknowledgement of your request to the Director of Insurance, you and your treating Provider.
   - Send the Director of Insurance: the request for review, your Aetna Certificate of Coverage or Group Insurance Certificate; all medical records and supporting documentation used to render Aetna's decision; a summary of the applicable issues including a statement of Aetna's decision, the criteria used and any clinical reasons for our decision and the relevant portions of Aetna's utilization review guidelines.

   Within 2 business days of receiving this information, the Director of Insurance must determine if the service or claim is covered, issue a decision, and send a notice to Aetna, you and your treating Provider.

The Director of Insurance is sometimes unable to determine issues of coverage. If this occurs, the Director of Insurance will forward your case to an IRO. The IRO will have 72 hours to make a decision and send it to the Director of Insurance. The Director of Insurance will have 48 hours after receiving the IRO's decision to send the decision to Aetna, you and your treating Provider.

Decision:

Medical Necessity Decision:

If the IRO decides that Aetna should provide the service, Aetna must authorize the service. If the IRO agrees with Aetna's decision to deny the service, the appeal is over. Your only further option is to pursue your claim in Superior Court.

Contract Coverage Decision:

If you disagree with the Director of Insurance's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If Aetna disagrees with the Director's final decision, Aetna may also request a hearing before the OAH. A hearing must be scheduled within 30 days of receiving the Director's decision. OAH must promptly schedule and complete a hearing for Appeals from Expedited External Independent Medical Review Appeals decisions.

STANDARD APPEAL PROCESS FOR NON-URGENT SERVICES AND DENIED CLAIMS

Informal Reconsideration (Level One)

Your request: You may obtain Informal Reconsideration of your denied request for a service or a denied claim for services already provided to you if:

- You have coverage with us;
- We denied your request for a covered service or denied your claim for services already provided,
- You do not qualify for an expedited appeal, and
- You or your treating provider asks for Informal Reconsideration within 2 years of the date we first deny the requested service or claim by calling, writing, or faxing your request to:

Name:	Aetna Health Inc.
Title:	Customer Resolution Team
Address:	P.O. Box 14002, Lexington, KY 40512
Phone:	1-800-545-2211
Fax:	859-425-3379

Our acknowledgement: Aetna has 5 business days after we receive your request for Informal Reconsideration ("the receipt date") to send you and your treating provider a notice that we received your request.

Our decision: Aetna has the following timeframes after the receipt date within which to decide whether we should change our decision and authorize your requested service or pay your claim. Within that same timeframe, we must send you and your treating provider our written decision. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request for a Pre-Service Claim - within 15 calendar days. A Pre-Service Claims is a claim for a benefit that requires approval of the benefit in advance of obtaining medical care. **You have 60 days to appeal to Level Two.**

If we deny your request for a Concurrent Care Claim Extension - within 15 calendar days. A Concurrent Care Claim Extension is a request to extend or a decision to reduce a previously approved course of treatment. **You have 60 days to appeal to Level Two.**

If we deny your request for a Post-Service Claim - within 30 calendar days. A Post-Service Claim is any claim for a benefit that is not a pre-service claim. **You have 60 days to appeal to Level Two**.

If we grant your request: The decision will authorize the service or pay the claim and the appeal process is complete.

If we refer your case to Level Three: We may decide to skip Level One and Level Two and send your case straight to an independent reviewer at Level Three.

You must exhaust the internal appeal process unless:

- We waive the exhaustion requirement
- We fail to comply with the requirements of the internal appeal process except for failures that are based on unimportant or minor violations

Formal Appeal (Level Two)

Your request: You may request a Formal Appeal if Aetna denied your request or claim at Level One. After you receive our Level One denial, you or your treating provider must send us a written request within 60 days to tell us you are appealing to Level Two. To help us make a decision on your appeal, you or your treating provider should also send us any more information (that you haven't already sent us) to show why we should authorize the requested service or pay the claim.

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

Send your appeal request and information to:

Name:	Aetna Health Inc.
Title:	Customer Resolution Team
Address:	P.O. Box 14002, Lexington, KY 40512
Phone:	1-800-545-2211
Fax:	859-425-3379

Our acknowledgement: Aetna has 5 business days after we receive your request for Formal Appeal ("the receipt date") to send you and your treating provider a notice that we received your request.

Our decision: For a denied service that you have not yet received, Aetna has the following timeframes after the receipt date within which to decide whether we should change our decision and authorize your requested service. We will send you and your treating provider our decision in writing. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request for a Pre-Service Claim - within 15 calendar days. A Pre-Service Claims is a claim for a benefit that requires approval of the benefit in advance of obtaining medical care. **You have four months to appeal to Level Three.**

If we deny your request for a Concurrent Care Claim Extension - within 15 calendar days. A Concurrent Care Claim Extension is a request to extend or a decision to reduce a previously approved course of treatment. **You have four months to appeal to Level Three.**

If we deny your request for a Post-Service Claim - within 30 calendar days. A Post-Service Claim is any claim for a benefit that is not a pre-service claim. **You have four months to appeal to Level Three**.

If we grant your request: We will authorize the service or pay the claim and the appeal process is complete.

If we refer your case to Level Three: We may decide to skip Level Two and send your case straight to an independent reviewer at Level Three.

External, Independent Review (Level Three)

Your request: You may obtain External Independent Medical Review only after you have sought any Appeals through standard and expedited Level One and Level Two. You have four months after receipt of written notice from Aetna that your Formal Appeal or Expedited Medical Review has been denied to request External Independent Medical Review. You must send a written request for External Independent Medical Review and any material justification or documentation to support your request for the covered service or claim for a covered service to:

Name:	Priscilla Bugari, R.N.
Title:	Director, Aetna National External Review Unit
Address:	1100 Abernathy Rd, Suite 375, Atlanta, GA 30328
Phone:	1-877-848-5855 (Toll-free number)
Fax:	860-975-1526

Neither the Member nor the Member's treating Provider is responsible for the cost of any External Independent Medical Review.

Process:

There are 2 types of External Independent Medical Review Appeals, depending on the issues in your case:

1. Medical Necessity Appeals are cases where Aetna has decided not to authorize a service because Aetna believes the service(s) you or your treating Provider are asking for, are not Medically Necessary to treat your condition or do not meet criteria for appropriateness, health care setting, level of care, or effectiveness of a covered benefit. The external independent reviewer is a Provider retained by an outside Independent Review Organization ("IRO") that is procured by the Arizona Department of Insurance, and not connected with Aetna. The IRO Provider must be one who typically manages the condition under review.

   Within 6 business days of receiving your or the Director of Insurance's request, or if Aetna initiates an External Independent Medical Review, Aetna must:
   - Mail a written acknowledgement to the Director of Insurance, you and your treating Provider.
   - Send the Director of Insurance: the request for review; your Certificate of Coverage or Group Insurance Certificate; all medical records and supporting

documentation used to render Aetna's decision; a summary of the applicable issues including a statement of Aetna's decision; the criteria used and clinical reasons for Aetna decision; and the relevant portions of Aetna's utilization review guidelines. We must also include the name and credentials of the Provider who reviewed and upheld the denial at the earlier Appeal levels.

Within 5 business days of receiving Aetna's information, the Director of Insurance must send all the submitted information to the external independent review organization (the "IRO").

Within 45 calendar days of receiving the information, the IRO must make a decision and send the decision to the Director of Insurance.

Within 5 business days of receiving the IRO's decision, the Director of Insurance will mail a notice of the decision to Aetna, you and your treating Provider.

2. Contract Coverage issues are Appeals where Aetna has denied coverage because Aetna believes the requested service is not covered under your Certificate of Coverage or Group Insurance Certificate. For these Appeals, the Arizona Department of Insurance is the external independent reviewer.

   Within 6 business days of receiving your request or if Aetna initiates an External Independent Medical Review, Aetna must:
   - Mail a written acknowledgement of your request to the Director of Insurance, you and your treating Provider.
   - Send the Director of Insurance: the request for review, your Certificate of Coverage or Group Insurance Certificate; all medical records and supporting documentation used to render Aetna's decision; a summary of the applicable issues including a statement of Aetna's decision, the criteria used and any clinical reasons for our decision and the relevant portions of Aetna's utilization review guidelines.

   Within 15 business days of receiving this information, the Director of Insurance will determine if the service or claim is covered, issue a decision, and send a notice of determination to Aetna, you and your treating Provider.

   The Director of Insurance is sometimes unable to determine issues of coverage. If this occurs or if the Director of Insurance finds that the case involves a medical issue, the Director of Insurance will forward your case to an IRO. The IRO will have 45 calendar days to make a decision and send it to the Director of Insurance. The Director of Insurance will have 5 business days after receiving the IRO's decision to send the decision to Aetna, you and your treating Provider.

Decision:

Medical Necessity Decision:

If the IRO decides that Aetna should provide the service, Aetna must authorize the service regardless of whether judicial review is sought. If the IRO agrees with Aetna's decision to deny the service, the Appeal is over. Your only further option is to pursue your claim in Superior Court. However, on written request by the IRO, you or Aetna, the Director of Insurance may extend the 45-day time period for up to an additional 30 days, if the requesting party demonstrates good cause for an extension.

Contract Coverage Decision:

If you disagree with the Director of Insurance's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If Aetna disagrees with the Director's final decision, Aetna may also request a hearing before the OAH. A hearing must be requested within 30 days of receiving the coverage issue determination. OAH has rules that govern the conduct of their hearing proceedings.

II. The Role of the Director of Insurance.

Arizona law (A.R.S. §20-2533(F)) requires "any Member who files a Complaint or Appeal with the Department relating to an adverse decision to pursue the review process prescribed" by law. This means, that for decisions that are appealable, you must complete the health care Appeals process before the Director of Insurance can investigate a Complaint or Appeal you may have against Aetna based on the decision at issue in the Complaint or Appeal.

The Appeal process requires the Director to:

1. Oversee the Appeals process.
2. Maintain copies of each utilization review plan submitted by Aetna.
3. Receive, process, and act on requests from Aetna for External Independent Medical Review.
4. Enforce the decisions of Aetna.
5. Review decisions of Aetna.
6. Report to the Legislature.
7. Send, when necessary, a record of the proceedings of an Appeal to Superior Court or to the Office of Administrative Hearings (OAH).
8. Issue a final administrative decision on coverage issues, including the notice of the right to request a hearing at the OAH.

III. Obtaining Medical Records.

Arizona law (A.R.S. §12-2293) permits the Member to ask for a copy of their medical records. Your request must be in writing and must specify who you want to receive the records. The health care Provider who has your records will provide you or the person you specify with a copy of your records.

Designated Decision-Maker: If you have a designated health care decision-maker, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your health care decision-maker or a person designated in writing by your health care decision-maker unless you limits access to your medical records only you or your health care decision-maker.

Confidentiality: Medical records disclosed under A.R.S. §12-2293 remain confidential. If you participate in the Appeal process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other people.

IV. Documentation for an Appeal.

If you decide to file an Appeal, you must give us any material justification or documentation for the Appeal at the time the Appeal is filed. If you gather new information during the course of your Appeal, you should give it to us as soon as you receive it. You must also give Aetna the address and phone number where you can be contacted. If the Appeal is already at Expedited External Independent Medical Review, you should also send the information to the Department.

V. **Receipt of Documents.**

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed (your last known address) on the fifth business day after being mailed.

VI. **Record Retention.**

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

VII. **Fees and Costs.**

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

AETNA HEALTH INC.
(ARIZONA)

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.
(ARIZONA)

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** 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.
(ARIZONA)

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

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

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.
(ARIZONA)

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 previously declined 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.
(ARIZONA)

AMENDMENT TO THE CERTIFICATE OF COVERAGE

Contract Holder Group Agreement Effective Date: January 1, 2013

The Emergency Care/Urgent Care Benefit within the Covered Benefits section of the **Certificate** is hereby amended as follows:

> Medical transportation is covered during a **Medical Emergency**, including **Medically Necessary** non-emergency transportation when approved by a **Participating Provider**.

AETNA HEALTH INC.
(ARIZONA)

WORKERS COMPENSATION AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

The following provision is hereby added to the **Certificate**:

RECOVERY RIGHTS RELATED TO WORKERS' COMPENSATION

If medical benefits are provided by **HMO** for illness or injuries to a **Member** and **HMO** determines the **Member** received Workers' Compensation benefits for the same incident that resulted in the illness or injuries, **HMO** has the right to recover those benefits as further described below. "Workers' Compensation benefits" includes benefits paid in connection with a Workers' Compensation claim, whether paid by an employer directly, a workers' compensation insurance carrier, or any fund designed to provide compensation for workers' compensation claims. **HMO** may exercise its Recovery Rights against the provider, if they have been paid by the carrier directly, or the **Member**, if they have received any payment to compensate them in connection with their claim.

The Recovery Rights will be applied even though:

a) The Workers' Compensation benefits are paid by means of settlement or compromise;

b) No final determination is made that bodily injury or sickness was sustained in the course of or resulted from the Member's employment but the **Member** receives a lump sum payment; or

c) The amount of Workers' Compensation benefits due to medical or health care is not agreed upon or defined by the **Member** or the Workers' Compensation carrier and the **Member** receives a lump sum payment.

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

HMO may exercise its Recovery Rights against the provider in the event:

a) the employer or carrier is found liable or responsible according to a final adjudication of the claim; or

b) an order of the Arizona Workers' Compensation Board approving a settlement agreement is entered; or

c) the provider has previously been paid by the carrier directly, resulting in duplicate payment.

AETNA HEALTH INC.
(ARIZONA)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

1. The **Direct Access Specialist Benefits** provision under the Covered Benefits section of the **Certificate** is hereby revised to include the following:

   Please review the **Chiropractic Benefits** provision under the Covered Benefits section of the **Certificate** for information regarding direct access for **chiropractic services.**

2. The **Chiropractic Benefits** provision under the Covered Benefits section of the **Certificate** is hereby revised to include the following:

   The **Member** is not required to obtain a **Referral** from their **PCP** to a **Participating Provider** for the first 12 visits per **calendar year**.

3. The second paragraph of the **Chiropractic Benefits** provision under the Covered Benefits section of the **Certificate** is hereby deleted and replaced with the following:

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

AETNA HEALTH INC.
(ARIZONA)

AMENDMENT TO CERTIFICATE OF COVERAGE

Contract Holder Group Agreement Effective Date: January 1, 2013

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

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

- **Medical Foods to Treat Inherited Metabolic Disorders and Formulas to Treat Eosinophilic Gastrointestinal Disorders.**

  Subject to the payment of the applicable **Copayment**, coverage is provided for expenses incurred for the purchase of:

  - **Medically Necessary Medical Foods** used in the therapeutic treatment of **Inherited Metabolic Disorders**, including **Modified Low Protein Foods** and **Metabolic Formula;** and
  - **Medically Necessary** amino acid-based formulas necessary for the treatment of Eosinophilic Gastrointestinal Disorders,

  when prescribed or ordered by the **Member's Participating Physician**.

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

- **Medical Foods** – **Modified Low Protein Foods** and **Metabolic Formula**.

- **Metabolic Formula** – foods that are all of the following:

  1. formulated to be consumed or administered internally under the supervision of the **Member's Participating Physician**.
  2. processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs.
  3. administered for the medical and nutritional management of a **Member** who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation.
  4. essential to a **Member's** optimal growth, health and metabolic homeostasis.

- **Modified Low Protein Foods** – foods that encompass those foods described above in items 1, 3 and 4 under the definition of **Metabolic Formula**, and also the following:

  processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein.

AETNA HEALTH INC.
(ARIZONA)

AMENDMENT TO THE CERTIFICATE OF COVERAGE

Contract Holder Group Agreement Effective Date: January 1, 2013

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

1. The periodic health evaluations coverage appearing in the Covered Benefits section of the **Certificate** is hereby deleted and replaced with the following:

    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;

        f. routine vision screenings.

AETNA HEALTH INC.
(ARIZONA)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Policy Effective Date: January 1, 2013

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

Health Maintenance Organization (HMO). Aetna Health Inc., a Pennsylvania corporation licensed by the Arizona 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.
(ARIZONA)

AMENDMENT TO THE CERTIFICATE OF COVERAGE
CONTINUATION COVERAGE FOR DEPENDENT STUDENTS ON MEDICAL LEAVE OF ABSENCE

Contract Holder Group Agreement Effective Date: January 1, 2013

The **HMO Certificate of Coverage** is hereby amended as follows:

The following sub-section “Continuation Coverage for Dependent Students on Medical Leave of Absence" is hereby added to the "Continuation and Conversion" section of the **Certificate**:

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.

AETNA HEALTH INC.
(ARIZONA)

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.

AETNA HEALTH INSURANCE COMPANY
(ARIZONA)

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.
(ARIZONA)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

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

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

AETNA HEALTH INC.
(ARIZONA)

ENROLLMENT ENDORSEMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

ELIGIBILITY AND ENROLLMENT

Subsection B.5 of 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.
(ARIZONA)

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.**

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.

AETNA HEALTH INC.
(ARIZONA)

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 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 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. 31 days, beginning on the date of the eligible individual's or eligible dependent's loss of other group health plan or other health insurance coverage; or

b. 60 days, beginning on the date the eligible individual or eligible dependent

(i) becomes eligible for premium assistance in connection with coverage under **HMO**, or

(ii) is no longer qualified for coverage under Medicaid or S-Chip.

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

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.
(ARIZONA)

MENTAL DISORDERS AND SUBSTANCE ABUSE BENEFITS

Contract Holder Group Agreement Effective Date: January 1, 2013

A. The **Mental Health Benefits** provision shown in the **Covered Benefits** section of the Certificate of Coverage is deleted. It is replaced with the **Mental Disorders Benefits** provision shown below.

Mental Disorders Benefits.

A **Member** is covered for treatment of **Mental Disorders** through **Participating Behavioral Health Providers**.

- Outpatient benefits are covered for short-term, outpatient evaluative and crisis intervention or home health mental health services, and are subject to the maximums, if any, shown on the Schedule of Benefits.

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

B. The **Substance Abuse Benefits** provision shown in the **Covered Benefits** section of the Certificate of Coverage is deleted. It is replaced with the **Substance Abuse Benefits** provision shown below.

Substance Abuse Benefits.

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

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

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

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

  Member is entitled to medical, nursing, counseling or therapeutic **Substance Abuse Rehabilitation** services in an inpatient, **Hospital** or non-hospital **Residential Treatment Facility**, appropriately licensed by the Department of Health, upon referral by the **Member's Participating Behavioral Health Provider** for alcohol or drug abuse or dependency. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.

C. The definition of **Mental or Behavioral Condition** shown in the **Definitions** section is deleted. It is replaced with the following definition of **Mental Disorder** as shown below:

- **Mental Disorder**

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

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

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

D. The following definition of **Psychiatric Physician** is added to the **Definitions** section:

- **Psychiatric Physician.** This is a **Physician** who:

  - Specializes in psychiatry; or
  - Has the training or experience to do the required evaluation and treatment of **Substance Abuse** or **Mental Disorders**.

AETNA HEALTH INC.
(ARIZONA)

AUTISM BENEFITS
AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc., ("**HMO**") **Certificate** is hereby amended as follows:

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

   Autism Spectrum Disorder: This means one of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

   (a) Autistic Disorder;

   (b) Asperger's Syndrome; and

   (c) Pervasive Developmental Disorder--Not Otherwise Specified.

   Behavioral Therapy means interactive therapies derived from evidence based research, including applied behavior analysis, which includes discrete trail training, pivotal response training, intensive intervention programs and early behavioral intervention.

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

   Autism Spectrum Disorder Benefits. **Covered Benefits** include treatment of **Autism Spectrum Disorders**. Treatment includes diagnosis, assessment and services, including **Behavioral Therapy** services provided or supervised by a **Behavioral Health Provider**. Unless otherwise indicated, **Autism Spectrum Disorders** will be treated like and at the same level as any other illness under this **Certificate.**

   Any provision that would otherwise exclude services for **Autism Spectrum Disorders** required by this benefit will apply.

   Applied Behavioral Analysis is an educational service that is the process of applying interventions:
   - that systematically change behavior; and
   - that are responsible for the observable improvement in behavior.

   Important: Applied Behavioral Analysis requires pre-authorization by the HMO and the Participating Provider is responsible for obtaining pre-authorization.

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

Benefit	**Deductible/Copayment**
Autism Spectrum Disorder Benefits	Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.

4. The **Covered Benefits** section of the **Certificate** is hereby amended. Items 3, 4, 5, 6 under Outpatient Rehabilitation Benefits are hereby deleted and replaced with the following:

3. 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** 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.

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.

Therapies for the treatment of delays in development, 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, Down Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature. This exclusion does not apply to physical therapy, occupational therapy or speech therapy provided for the treatment of **Autism Spectrum Disorders**. Physical therapy, occupational therapy and speech therapy services for the treatment of **Autism Spectrum Disorder** are subject to the maximum shown in the Schedule of Benefits applicable to this coverage for these covered expenses.

AETNA HEALTH INC.
(ARIZONA)

CERTIFICATE OF COVERAGE AND
SCHEDULE OF BENEFITS
AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. **Certificate** and Schedule of Benefits are hereby amended as follows:

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

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

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

- Any overall plan Calendar Year; **Contract Year**; or Lifetime Maximum Benefits that are dollar maximums in the Schedule of Benefits no longer apply. All references to these overall plan dollar maximums that may appear in the Schedule of Benefits and **Certificate**, including any amendments or Riders, which have been issued to the **Member** are removed.

- The following Preventive Care services are **Covered Benefits**, and will be paid at 100% with no cost-sharing such as **Copayment**, **Deductibles** and dollar maximum benefits:

  - Routine Adult Physical Examinations (including immunizations, routine vision and hearing screenings);
  - Routine Well Child Care (including immunizations);
  - Routine Cancer Screenings (which include Screening Mammograms; Prostate Specific Antigen (PSA) Tests; Digital-Rectal Exams (DRE); Fecal Occult Blood Tests (FOBT); Sigmoidoscopies; Double Contrast Barium Enemas (DCBE) and Colonoscopies); and
  - Routine Gynecological Exams, including routine Pap smears.

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

  - the most recently published preventive health care guidelines as required by the Federal Department of Health and Human Services; or
  - the state laws and regulations that govern the **Group Agreement**.

- Any calendar year; **Contract Year**; or lifetime dollar maximum benefit that applies to an "Essential Service" (as defined by the Federal Department of Health and Human Services) listed below, no longer applies.

  If the following Essential Services are **Covered Benefits** under the **Member's Certificate**, and such **Covered Benefits** include these dollar maximums, then the maximums are removed from the Schedule of Benefits and **Certificate**, including any amendments or riders, which have been issued to the **Member**:

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

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

Essential Services will continue to be subject to any **Copayments**, **Deductibles**, other types of maximums (e.g., day and visit), **Referral** and pre-authorization rules, and exclusions and limitations that apply to these **Covered Benefits** as indicated in the Schedule of Benefits and **Certificate**, including any amendments or riders.

- Office visits for obstetrical care, including preventive, routine and diagnostic, are now Direct Access Specialist Benefits and are covered without a **Referral** or pre-authorization when rendered by a **Participating Provider**.

AETNA HEALTH INC.
(ARIZONA)

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 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 non-office hour **Urgent Care** services under this plan. 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 **Urgent Care** 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 will be the **Member's** responsibility.

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**.

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 and a **Member** will be responsible for all expenses incurred unless **HMO** 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 prior written **Referral** issued by the **Member's PCP** or certified by **HMO**. 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** including but not limited to **Hospital** admissions and outpatient surgery. **Participating Providers** are responsible for obtaining pre-authorization of **Covered Benefits** from **HMO**.

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.
(Arizona)

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 6 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

x. and is of the same sex as the **Subscriber**.

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

AETNA HEALTH INC.
(ARIZONA)

PRESCRIPTION LENS 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.

  If the **Providers** have an agreement with **HMO** to bill **HMO** directly, the allowance will be directly deducted from the cost of the prescription lenses or frames.

The 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.
ARIZONA

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.
(ARIZONA)

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 listing of prescription drugs and insulin established by **HMO** or an affiliate that includes both **Brand Name Prescription Drugs**, and **Generic Prescription Drugs,** created to give the **Members** access to quality, affordable medications. 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.

  HMO offers pharmacy benefits plans with either an open or closed **Drug Formulary**. The key difference between an open and closed **Drug Formulary** is that prescription drugs on the **Drug Formulary Exclusions List** are not covered for **Members** in a closed **Drug Formulary** benefits plan unless a medical exception is obtained.

  Prescription drugs that are considered for our **Drug Formulary** are extensively reviewed. The **HMO's** Pharmacy Quality Advisory Committee (PQAC) and Pharmacy and Therapeutics (P&T) Committee each meet regularly to review drugs that have been approved by the FDA. Practicing pharmacists and **Physicians** who are **Participating Providers** in our network serve on the PQAC. This committee reviews available clinical information on the prescription drugs being considered. The PQAC then provides its qualitative comments to the P&T Committee.

  After evaluating information from different sources, the P&T Committee places prescription drugs into one of three categories:

  Category I: The prescription drug represents an important therapeutic advance. (These prescription drugs are always included on the **Drug Formulary**.)

  Category II: The prescription drug is clinically and therapeutically similar to other available products. (These prescription drugs are reviewed by **HMO** for overall value, including their cost and manufacturer volume-discount arrangements before being placed on the **Drug Formulary**.)

  Category III: The prescription drug has significant disadvantages in safety or effectiveness when compared with other similar products. (These prescription drugs are always excluded from the **Drug Formulary**.)

Since **HMO** regularly evaluates both new and existing therapies, the **Drug Formulary** is often subject to change.

- **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.

- **Inherited Metabolic Disorder** – a disease caused by an inherited abnormality of body chemistry and includes a disease tested under the Newborn Screening Program.

- **Medical Foods – Modified Low Protein Foods** and **Metabolic Formula.**

- **Metabolic Formula** – foods that are all of the following:

  1. formulated to be consumed or administered internally under the supervision of the **Member's Participating Physician.**

  2. processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs.

  3. administered for the medical and nutritional management of a **Member** who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation.

  4. essential to a **Member's** optimal growth, health and metabolic homeostasis.

- **Modified Low Protein Foods** – foods that encompass those foods described above in items 1, 3 and 4 under the definition of **Metabolic Formula**, and also the following:

  1. processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein.

- **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 30 day supply when filled at a **Participating Retail Pharmacy** or 90 day supply when filled by the **Participating 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 the **Precertification Program**, 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 as a safe and effective treatment of such indication in at least 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).

If the safety and effectiveness of use for this indication has been adequately demonstrated by at least two studies published in a nationally recognized major peer reviewed professional medical journal, and if no study from a major peer reviewed professional medical journal has concluded that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of this indication, and the literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the International Committee of Medical Journal Editors or is published in a journal specified by the United States Department of Health and Human Services as acceptable peer reviewed medical literature, medical literature may also be accepted in lieu of the standard reference compendia requirement above.

This coverage of the off-label use of a prescription drug includes covered **Medically Necessary** services associated with the administration of the prescription drug.

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. **Members** are required to obtain prescriptions greater than a 30 day supply from the designated **Participating Mail Order Pharmacy**. 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 and Equipment.**

  Subject to payment of the applicable **Copayment**, the following **Medically Necessary** Diabetes supplies and equipment prescribed by a **Participating Physician** and obtained through a **Participating Retail** or **Mail Order Pharmacy**:

  1. Blood glucose monitors, including those for the legally blind;
  2. Test strips;
  3. Insulin preparation and glucagon;
  4. Insulin cartridges, including those for the legally blind;
  5. Drawing devices and monitors for the visually impaired;
  6. Injection aids;
  7. Syringes and lancets, including automatic lancing devices;
  8. Any other device, medication, equipment or supply for which coverage is required under Medicare after January 1, 1999 and is eligible for coverage under this rider. Such coverage is effective within six (6) months after it is required by Medicare;
  9. Oral agents included on the plan formulary for controlling blood sugar.

Any Maximum Prescription Benefit that may apply to this Prescription Plan Rider does not apply to this item.

- **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.

- **Medical Foods to Treat Inherited Metabolic Disorders.**

  Subject to the payment of the applicable **Copayment**, coverage is provided for expenses incurred for the purchase of **Medically Necessary Medical Foods** used in the therapeutic treatment of **Inherited Metabolic Disorders**, including **Modified Low Protein Foods** and **Metabolic Formula,** when prescribed or ordered by the **Member's Participating Physician**.

  The cost of all **Medically Necessary Modified Low Protein Foods** and **Metabolic Formula** is subject to a $5,000 calendar year maximum benefit.

G. **Copayments:**

Member is responsible for the **Copayments** specified in this rider. The **Copayment,** if any, is payable directly to the **Participating Retail** or **Mail Order Pharmacy** for each prescription or refill at the time the prescription or refill is dispensed. If the **Member** obtains more than a 30 day supply of prescription drugs 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 Limitation 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**, except insulin.
4. Cosmetic or any drugs used for cosmetic purposes or to promote hair growth, including health and beauty aids.
5. Needles and syringes, except diabetic needles and syringes.
6. 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**.
7. Immunization or immunological agents, including biological sera, blood, blood plasma or other blood products administered on an outpatient basis, allergy sera and testing materials.
8. Drugs used for the purpose of weight reduction (e.g., appetite suppressants), including the treatment of obesity.
9. 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.
10. 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.
11. 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.
12. Medical supplies, devices and equipment and non-medical supplies or substances regardless of their intended use except when utilized in the treatment of Diabetes and is eligible for coverage under this rider.
13. Test agents and devices, except diabetic test agents.
14. Injectable drugs used for the purpose of treating **Infertility**, unless otherwise covered by **HMO**.
15. Injectable drugs, except for insulin.
16. Prescription orders filled prior to the effective date or after the termination date of the coverage provided by this rider.
17. Replacement for lost or stolen prescriptions.
18. Performance, athletic performance or lifestyle enhancement drugs and supplies.
19. 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.
20. 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.
21. Medication packaged in unit dose form. (Except those products approved for payment by **HMO).**
22. Prophylactic drugs for travel.
23. Drugs recently approved by the FDA, but which have not yet been reviewed by the Aetna Health Inc. Pharmacy Management Department and Therapeutics Committee.
24. Drugs for the convenience of **Members** or for preventive purposes.
25. 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.
26. Sildenafil citrate, phentolamine, apomorphine and alprostadil in oral, injectable and topical (including 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.
27. Nutritional supplements.

28. Smoking cessation aids or drugs.
29. Growth hormones.
30. 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.
(ARIZONA)

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 Drugs** 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 initial prescription must be filled at a **Participating Retail Pharmacy, Participating Mail Order Pharmacy** or **Specialty Pharmacy Network** pharmacy. All refills must be filled by a **Specialty Pharmacy Network** pharmacy. Coverage of **Self-injectable Drugs** may, in **HMO's** sole discretion, 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, in **HMO's** sole discretion, 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.
(ARIZONA)

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 following **Medical Food – Modified Low Protein Food and Metabolic Formula**, **Metabolic Formula**, and **Modified Foods to Treat Inherited Metabolic Disorders** Definitions are hereby deleted in their entirety:

- **Medical Foods** – **Modified Low Protein Foods** and **Metabolic Formula**.

- **Metabolic Formula** – foods that are all of the following:

  1. formulated to be consumed or administered internally under the supervision of the **Member's Participating Physician**.
  2. processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs.
  3. administered for the medical and nutritional management of a **Member** who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation.
  4. essential to a **Member's** optimal growth, health and metabolic homeostasis.

- **Modified Low Protein Foods** – foods that encompass those foods described above in items 1, 3 and 4 under the definition of **Metabolic Formula**, and also the following:

  1. processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein.

The following **Medical Foods to Treat Inherited Metabolic Disorders** benefit appearing in the Covered Benefits section of the Prescription Plan Rider is hereby deleted in its entirety:

- **Medical Foods to Treat Inherited Metabolic Disorders.**

  Subject to the payment of the applicable **Copayment**, coverage is provided for expenses incurred for the purchase of **Medically Necessary Medical Foods** used in the therapeutic treatment of **Inherited Metabolic Disorders**, including **Modified Low Protein Foods** and **Metabolic Formula,** when prescribed or ordered by the **Member's Participating Physician**.

  The cost of all **Medically Necessary Modified Low Protein Foods** and **Metabolic Formula** is subject to a $5,000 calendar year maximum benefit.

AETNA HEALTH INC.
(ARIZONA)

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: 639
Contract Holder Service Areas: AZ01

BENEFITS

Benefit	Maximums
Maximum Out-of-Pocket Limit **Does not apply to Prescription Drug Benefits.**	
Individual Limit	**$3,500 per calendar year**
Family Limit	**$10,500 per calendar year**
The family Maximum Out-of-Pocket Limit is a cumulative Maximum Out-of-Pocket Limit for all family members. **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 **Visits are subject to the following visit maximum:**	**$0 per visit**
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 (Non-surgical)	**$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	
Treatment over a 60 consecutive day period per incident of illness or injury beginning with the first day of treatment	**$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**
Chiropractic Benefits	
20 visits per calendar year	**$20 per visit**
Diagnostic Laboratory Testing	**$0 per visit**
Outpatient Emergency Services (Participating)	
Hospital Emergency Room or Outpatient Department	**$50 per visit**
Outpatient Emergency Services (Non-Participating)	
Hospital Emergency Room or Outpatient Department	**$50 per visit**
Urgent Care Facility	**$25 per visit**
Ambulance	**$0 per trip**
Outpatient Mental Disorders Visits	**$10 per visit**
Outpatient Substance Abuse Visits	
Detoxification	**$10 per visit/day**
Outpatient Substance Abuse Visits	
Rehabilitation	**$10 per visit/day**
Outpatient Surgery	**$50 per visit**
Outpatient Home Health Visits	**$0 per visit**
Outpatient Hospice Care Visits	**$0 per visit**
Injectable Medications	**$10 per visit or per prescription or refill**

Medical Foods to Treat Inherited Metabolic Disorders and Formulas to Treat Eosinophilic Gastrointestinal Disorders	
Medical Foods to Treat Inherited Metabolic Disorders	**50% (of the contracted rate) after Deductible per medical food product**
Formulas to Treat Eosinophilic Gastrointestinal Disorders	**25% (of the contracted rate) after Deductible per formula**

INPATIENT BENEFITS

Benefit	**Copayment**
Acute Care	**$100 per admission**
Mental Disorders	
During a Hospital Confinement	**$100 per admission**
During a Residential Treatment Facility Confinement Maximum of Unlimited days per calendar year	**$100 per admission (waived if a Member is transferred from a Hospital to a Residential Treatment Facility)**
Substance Abuse Detoxification and Rehabilitation	
During a Hospital Confinement	**$100 per admission**
During a Residential Treatment Facility Confinement Maximum of Unlimited days per calendar year	**$100 per admission (waived if a Member is transferred from a Hospital to a Residential Treatment Facility)**
Maternity	**$100 per admission**
Skilled Nursing Facility	
Maximum of 100 days per calendar year	**$100 per admission (waived if a Member is transferred from a Hospital to a Skilled Nursing Facility)**
Hospice Care	**$0 per admission (waived if a Member is transferred from a Hospital to a Hospice Care facility)**
Transplant	
Transplant Facility Expense Services	
Inpatient Care	**$100 per admission**

ADDITIONAL BENEFITS

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

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 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 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 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.