AETNA HEALTH INC.
6501 S. FIDDLER'S GREEN CIRCLE
SUITE 310
GREENWOOD VILLAGE, CO 80111

(COLORADO)

GROUP AGREEMENT COVER SHEET

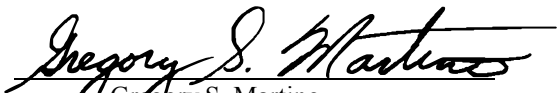
Contract Holder:	The Government of the District of Columbia
Contract Holder Number:	172614 749
HMO Referred Benefit Level:	CITIZEN OPEN ACCESS PLAN Benefits Package
Effective Date:	12:01 a.m. on January 1, 2013
Term of **Group Agreement:**	The **Initial Term** shall be: From January 1, 2013 through December 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 COLORADO

Notice Address for **HMO**

1425 Union Meeting Road
Post Office Box 1445
Blue Bell, PA 19422

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: 749
Contract Holder Group Agreement Effective Date: January 1, 2013

AETNA HEALTH INC.
6501 S. FIDDLER'S GREEN CIRCLE
SUITE 310
GREENWOOD VILLAGE, CO 80111

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**, a late payment charge of 1½% of the total amount due per month (or partial month) will be added to the amount due. If all **Premiums** and fees are not received before the end of a 30 day grace period (the **"Grace Period"**), this **Group Agreement** will be automatically terminated pursuant to Section 6.3 hereof.

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

The **Contract Holder** shall pay **Premium** for every **Member** covered under the **Group Agreement** through the date that the **Contract Holder** notifies **Us** of the date the **Contract Holder** intends to terminate this **Group Agreement**.

The **Contract Holder** is required to pay **Premiums** up to the date that the **Contract Holder** notifies **Us** of their intent to not maintain coverage under the **Group Agreement**.

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.

Contract Holder shall pay the required total monthly **Premium** for additions and deletions of **Members** during any month as follows:

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

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

SECTION 4. ENROLLMENT

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

- at least once during every twelve month period during the **Open Enrollment Period**; and

- within 31 days from the date the individual and any dependent becomes eligible for coverage.

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

4.2 **Waiting Period.** There may be a waiting period before individuals are eligible for coverage under this **Group Agreement**. The waiting period, if any, is specified on the **Schedule of Benefits**.

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

SECTION 5. RESPONSIBILITIES OF THE CONTRACT HOLDER

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

5.1 **Records.** Furnish to **Us**, on a monthly basis (or as otherwise required), on our form (or such other form as **We** may reasonably approve) by facsimile (or such other means as **We** may reasonably approve), such information as **We** may reasonably require to administer this **Group Agreement**. This includes, but is not limited to, information needed to enroll members of the **Contract Holder**, process terminations, and effect changes in family status and transfer of employment of **Members**. **We** will not be liable to **Members** for the fulfillment of any obligation prior to information being received in a form satisfactory to **Us**. **Contract Holder** must notify **Us** of the date in which a **Subscriber's** employment ceases for the purpose of termination of coverage under this **Group Agreement**. Subject to applicable law, unless otherwise specifically agreed to in writing, **We** will consider **Subscriber's** employment to continue until the earlier of:

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

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

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

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

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

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

SECTION 6. TERMINATION

6.1 **Termination by Contract Holder.** This **Group Agreement** may be terminated by **Contract Holder** as of any **Premium Due Date** by providing **Us** with 30 days prior written notice. However, **We** may in **Our** discretion accept an oral indication by **Contract Holder** or it's agent or broker of intent to terminate.

6.2 **Non-Renewal by Contract Holder.** **We** may request from **Contract Holder** a written indication of their intention to renew or non-renew this **Group Agreement** at any time during the final three months of any **Term**. If **Contract Holder** fails to reply to such request within the timeframe specified the **Contract Holder** shall be deemed to have provided notice of non-renewal to **Us** and this **Group Agreement** shall be deemed to terminate automatically as of the end of the **Term**. Similarly, upon **Our** written confirmation to **Contract Holder**, **We** may accept an oral indication by **Contract Holder** or its agent or broker of intent to non-renew as **Contract Holder's** notice of termination effective as of the end of the **Term**.

6.3 **Termination by Us.** This **Group Agreement** will terminate as of the last day of the **Grace Period** if the **Premium** remains unpaid at the end of the **Grace Period**.

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

- Immediately upon notice to **Contract Holder** if **Contract Holder** has performed any act or practice that constitutes fraud or made any intentional misrepresentation of a material fact relevant to the coverage provided under this **Group Agreement**;

- Immediately upon notice to **Contract Holder** if **Contract Holder** no longer has any enrollee under the Plan who resides or works in the **Service Area**;

- Upon 30 days written notice to **Contract Holder** if **Contract Holder** (i) breaches a provision of this **Group Agreement** and such breach remains uncured at the end of the notice period; (ii) ceases to meet **Our** requirements for an employer group or association; (iii) fails to meet **Our** contribution or participation requirements applicable to this **Group Agreement** (which contribution and participation requirements are available upon request); (iv) fails to provide the certification required by Section 5.4 within a reasonable period of time specified by **Us**; or (v) changes its eligibility or participation requirements without **Our** consent;

- Upon 90 days written notice to **Contract Holder** (or such shorter notice as may be permitted by applicable law, but in no event less than 30 days) if **We** cease to offer the product to which the **Group Agreement** relates;

- Upon 180 days written notice to **Contract Holder** (or such shorter notice as may be permitted by applicable law, but in no event less than 30 days) if **We** cease to offer coverage in a market in which **Members** covered under this **Group Agreement** reside;

- Upon 30 days written notice to **Contract Holder** for any other reason which is acceptable to the Department of Insurance and consistent with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or by applicable federal rules and regulations, as amended.

6.4 **Effect of Termination.** No termination of this **Group Agreement** will relieve either party from any obligation incurred before the date of termination. When terminated, this **Group Agreement** and all coverage provided hereunder will end at 12:00 midnight on the effective date of termination. **We** may charge the **Contract Holder** a reinstatement fee if coverage is terminated and subsequently reinstated under this **Group Agreement**. Upon termination, **We** will provide **Members** with Certificates of Creditable Coverage which will show evidence of a **Member's** prior health coverage with **Us** for a period of up to 18 months prior to the loss of coverage.

6.5 **Notice to Subscribers and Members.** It is the responsibility of **Contract Holder** to notify the **Members** of the termination of the **Group Agreement** in compliance with all applicable laws. However, **We** reserve the right to notify **Members** of termination of the **Group Agreement** for any reason, including non-payment of **Premium**. In accordance with the **Certificate**, the **Contract Holder** shall provide written notice to **Members** of their rights upon termination of coverage.

SECTION 7. PRIVACY OF INFORMATION

7.1 **Compliance with Privacy Laws.** **We** and **Contract Holder** will abide by all applicable laws and regulations regarding confidentiality of individually identifiable health and other personal information, including the privacy requirements of HIPAA.

7.2 **Disclosure of Protected Health Information.** 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 solely responsible for any health services rendered to their **Member** patients. **We** make no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any **Physician**, **Hospital** or other **Participating Provider**. A **Provider's** participation may be terminated at any time by either party in accordance with notification requirements or without advance notice to the **Contract Holder** or **Members** if beyond **HMO's** control. **Participating Providers** provide health care diagnosis, treatment and services for **Members**. **We** administer and determine plan benefits.

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

SECTION 9. MISCELLANEOUS

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

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

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

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

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

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

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

9.6 **Claim Determinations.** **We** have complete authority to review all claims for **Covered Benefits** under this **Group Agreement**. In exercising such responsibility, **We** shall have discretionary authority to determine whether and to what extent eligible individuals and beneficiaries are entitled to coverage and to construe any disputed or doubtful terms under this **Group Agreement,** the **Certificate** or any other document incorporated herein. **We** shall be deemed to have properly exercised such authority unless **We** abuse our discretion by acting arbitrarily and capriciously. **Our** review of claims may include the use of commercial software (including Claim Check) and other tools to take into account factors such as an individual's claims history, a **Provider's** billing patterns, complexity of the service or treatment, amount of time and degree of skill needed and the manner of billing.

9.7 **Misstatements.** If any fact as to the **Contract Holder** or a **Member** is found to have been misstated, an equitable adjustment of **Premiums** may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

9.8 **Incontestability.** Except as to a fraudulent misstatement, or issues concerning **Premiums** due:

- No statement made by **Contract Holder** or any **Member** shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing.
- No statement made by **Contract Holder** shall be the basis for voiding this **Group Agreement** after it has been in force for two years from its effective date.

9.9 **Assignability.** No rights or benefits under this **Group Agreement** are assignable by **Contract Holder** to any other party unless approved by **HMO**.

9.10 **Waiver.** **Our** failure to implement, or insist upon compliance with, any provision of this **Group Agreement** or the terms of the **Certificate** incorporated hereunder, at any given time or times, shall not constitute a waiver of **Our** right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of **Premiums** or benefits. This applies whether or not the circumstances are the same.

9.11 **Notices.** Any notice required or permitted under this **Group Agreement** shall be in writing and shall be deemed to have been given on the date when delivered in person; or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid, and properly addressed to the address set forth in the Group Application or Cover Sheet, or to any more recent address of which the sending party has received written notice or, if delivered by facsimile or other electronic means, on the date sent by facsimile or other electronic means.

9.12 **Third Parties.** This **Group Agreement** shall not confer any rights or obligations on third parties except as specifically provided herein.

9.13 **Non-Discrimination.** **Contract Holder** agrees to make no attempt, whether through differential contributions or otherwise, to encourage or discourage enrollment in **HMO** of eligible individuals and eligible **Dependents** based on health status or health risk.

9.14 **Applicable Law.** This **Group Agreement** shall be governed and construed in accordance with applicable federal law and the law of the state specified in the Cover Sheet or, if no state law is specified, **Our** domicile state.

9.15 **Inability to Arrange Services.** If due to circumstances not within **Our** reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of **Our Participating Providers** or entities with whom **We** have contracted for services under this **Group Agreement**, or similar causes, the provision of medical or **Hospital** benefits or other services provided under this **Group Agreement** is delayed or rendered impractical, **We** shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid **Premiums** held by **Us** on the date such event occurs. **We** are required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

9.16 **Use of the HMO Name and all Symbols, Trademarks, and Service Marks.** **We** reserve the right to control the use of **Our** name and all symbols, trademarks, and service marks presently existing or subsequently established. **Contract Holder** agrees that it will not use such name, symbols, trademarks, or service marks in advertising or promotional materials or otherwise without **Our** prior written consent and will cease any and all usage immediately upon **Our** request or upon termination of this **Group Agreement**.

9.17 **Dispute Resolution.** Any controversy, dispute or claim between **Us** on the one hand and one or more **Interested Parties** on the other hand arising out of or relating to the **Group Agreement**, whether stated in tort, contract, statute, claim for benefits, bad faith, professional liability or otherwise ("Claim"), shall be settled by confidential binding arbitration administered by the American Arbitration Association ("AAA") before a sole arbitrator ("Arbitrator"). Judgment on the award rendered by the Arbitrator ("Award") may be entered by any court having jurisdiction thereof. If the AAA declines to administer the case and the parties do not agree on an alternative administrator, a sole neutral arbitrator shall be appointed upon petition to a court having jurisdiction. **We** and **Interested Parties** hereby give up our rights to have Claims decided in a court before a jury.

Any Claim alleging wrongful acts or omissions of **Participating** or **Non-Participating Providers** shall not include **HMO**. A **Member** must exhaust all grievance, appeal and independent external review procedures prior to the commencement of an arbitration hereunder. No person may recover any damages arising out of or related to the failure to approve or provide any benefit or coverage beyond payment of or coverage for the benefit or coverage where (i) **We** have made available independent external review and (ii) **We** have

followed the reviewer's decision. No **Interested Party** may participate in a representative capacity or as a member of any class in any proceeding arising out of or related to the **Group Agreement**. This agreement to arbitrate shall be specifically enforced even if a party to the arbitration is also a party to another proceeding with a third party arising out of the same matter.

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

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

HEALTH CARE REFORM CONTRIBUTION CHANGE NOTICE

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

AETNA HEALTH INC.
6051 S. Fiddler's Green Circle
Suite 310
Greenwood Village, CO 80111
(COLORADO)

GROUP AGREEMENT AMENDMENT
TRANSITION CREDITS

Contract Holder Group Agreement Effective Date: January 1, 2013

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

Section 3, Premiums and Fees is amended to include the following:

Transition Credit Assistance Payment

Notwithstanding any provision in the **Group Agreement** to the contrary, **We** may allow a one-time transition credit assistance payment to offset **Contract Holder**'s expenses in replacing coverage from another carrier or health plan with the coverage provided by this **Group Agreement**, provided that **Contract Holder** meets Our underwriting criteria specific to transition credit assistance. Upon request of the **Contract Holder**, part or all of the transition credit assistance payment will be applied against the payment of **Premium**s or in any manner as agreed by the **Contract Holder** and **Us**.

AETNA HEALTH INC.
(COLORADO)

GROUP AGREEMENT AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

1) Section 3.6 of the Group Agreement is hereby deleted and replaced with the following:

3.6 **Membership Adjustments.** **We** may 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 months 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 based upon eligibility guidelines, as set forth in the **Certificate**, and are subject to the payment of all applicable **Premiums**.

Our determinations, interpretations, and decisions on these matters are subject to de novo review by an impartial reviewer as provided in this Group Agreement or as allowed by law. **Members** and beneficiaries are entitled to have their claims reviewed de novo in any court with jurisdiction and to a trial by jury.

2) Section 6.1 of the Group Agreement is hereby deleted and replaced with the following:

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 accept an oral indication by **Contract Holder** or it's agent or broker of intent to terminate.

Our determinations, interpretations, and decisions on these matters are subject to de novo review by an impartial reviewer as provided in this Group Agreement or as allowed by law. **Members** and beneficiaries are entitled to have their claims reviewed de novo in any court with jurisdiction and to a trial by jury.

3) Section 9.1 of the Group Agreement is hereby deleted and replaced with the following:

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 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.

Our determinations, interpretations, and decisions on these matters are subject to de novo review by an impartial reviewer as provided in this Group Agreement or as allowed by law. **Members** and beneficiaries are entitled to have their claims reviewed de novo in any court with jurisdiction and to a trial by jury.

4) Section 9.6 of the Group Agreement is hereby deleted and replaced with the following:

9.6 **Claim Determinations. We** have authority to review all claims for **Covered Benefits** under this **Group Agreement**. In exercising such responsibility, **We** shall have 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. **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.

Our determinations, interpretations, and decisions on these matters are subject to de novo review by an impartial reviewer as provided in this Group Agreement or as allowed by law. **Members** and beneficiaries are entitled to have their claims reviewed de novo in any court with jurisdiction and to a trial by jury.

AETNA HEALTH INC.
(COLORADO)

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.
6501 S. FIDDLER'S GREEN CIRCLE
SUITE 310
DENVER, CO 80111

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 Colorado.

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.

MEMBER'S WILL BE RESPONSIBLE TO PAY DIRECTLY TO THE PROVIDER COSTS FOR SERVICES OBTAINED BY THE MEMBER WHICH ARE NOT COVERED UNDER THIS CERTIFICATE OR FOR WHICH MEMBER DID NOT OBTAIN THE REQUIRED REFERRAL.

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.

IF A MEMBER HAS QUESTIONS REGARDING MEMBER SERVICES, PROBLEMS OR QUESTIONS OR QUESTIONS REGARDING COVERAGE UNDER THIS CERTIFICATE, THE MEMBER MAY CALL THE MEMBER SERVICES TOLL-FREE TELEPHONE NUMBER LISTED ON THE MEMBER'S IDENTIFICATION CARD OR DIRECT THEIR QUESTIONS TO THE FOLLOWING ADDRESS:

AETNA HEALTH INC.
6501 S. FIDDLER'S GREEN CIRCLE,
SUITE 310
DENVER, CO 80111

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

Notice:

As to residents of Colorado, HMO has contracted with Participating Providers* in counties in Colorado, as listed below, to provide medical coverage under this Plan at the time this information was prepared.

ADAMS
ARAPAHOE
BOULDER
DENVER
DOUGLAS
ELBERT
EL PASO
FREMONT
GARFIELD
GILPIN
JEFFERSON
LARIMER
LINCOLN
MESA
PUEBLO
TELLER
WELD

Notice:

As to residents of Colorado, HMO has NOT contracted with Participating Providers* in counties in Colorado, as listed below, to provide medical coverage under this Plan at the time this information was prepared.

ALAMOSA
ARCHULETA
BACA
BENT
BROOMFIELD
CHAFFEE
CHEYENNE
CLEAR CREEK
CONEJOS
COSTILLA
CROWLEY
CUSTER
DELTA
DOLORES
EAGLE
GRAND
GUNNISON
HINSDALE
HUERFANO
JACKSON
KIOWA
KIT CARSON
LAKE
LA PLATA
LAS ANIMAS
LOGAN
MINERAL
MOFFAT
MONTEZUMA
MONTROSE
MORGAN
OTERO
OURAY
PARK
PHILLIPS
PITKIN
PROWERS
RIO BLANCO
RIO GRANDE
ROUTT
SAGUACHE
SAN JUAN
SAN MIGUEL
SEDGWICK
SUMMIT
WASHINGTON
YUMA

* **For up-to-date information regarding Participating Providers, please refer to your Provider Directory or visit DocFind®, HMO's electronic provider directory, at www.aetna.com. While HMO's goal is to provide accurate information, provider network composition is subject to change without notice because a provider may terminate its contract, HMO may terminate the provider's contract, or for other reasons. In addition, present or future participation by a particular provider cannot be guaranteed for in-network benefits. Before receiving services, members should always verify that the providers they choose are Participating in our network.**

II. 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. Therefore, the Member should not receive any balance billings for those services which are provided or referred by a Member's PCP. The Member may be balance billed for services rendered by a Non-Participating Provider.

III. For questions regarding Non-Preferred Care Provider reimbursement rates, please contact the Member Services toll-free number on your ID Card.

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

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 entire cost of any such non-covered services will be the **Member's** responsibility.

C. **Availability of Providers.**

HMO cannot guarantee the availability or continued participation of a particular **Provider**. Either **HMO** or any **Participating Provider** may terminate the **Provider** contract or limit the number of **Members** that will be accepted as patients. If the **PCP** initially selected cannot accept additional patients, the **Member** will be notified and given an opportunity to make another **PCP** selection. The **Member** must then cooperate with **HMO** to select another **PCP**. Until a **PCP** is selected, benefits are limited to coverage for **Medical Emergency Care**.

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** ID 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 Procedures/Complaints and Appeals 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. **Requesting a Standing Referral.**

Member with (i) a life-threatening condition or disease or (ii) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request that a **Participating Specialist** or **Participating Specialty Care Center** assume responsibility for providing or coordinating the **Member**'s medical care, including primary and specialty care. A **Member** may make this request through the **Member**'s selected **PCP**. If **HMO**, or the **PCP**, in consultation with an **HMO** medical director and **Specialist**, if any, determines that the **Member's** care would most appropriately be coordinated by a **Participating Specialist** or **Participating Specialty Care Center, PCP** will authorize a **Standing Referral** to such **Participating Specialist** or **Participating Specialty Care Center**.

Any authorized **Referral** shall be made pursuant to a treatment plan approved by **HMO** in consultation with the **PCP**, the **Participating Specialist** or **Participating Specialty Care Center**, the **Member** or the **Member's** designee. The approved **Participating Specialist** or **Participating Specialty Care Center** will be permitted to treat the **Member** without further **Referral** from the **Member's PCP** and may authorize such **Referrals**, procedures, tests and other **Medical Services** as the **Member**'s **PCP** would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan. The **Participating Specialist** or **Participating Specialty Care Center** must refer the **Member** back to the **PCP** for primary care services.

H. **Colorado Access Plan(s).**

The Colorado Consumer Protection Standards Act for the operation of Managed Care Plans (§10-16-704(9) of the Colorado Revised Statutes), requires a carrier to maintain an "access plan" for each managed care network that the carrier offers in Colorado. In general, an access plan lists **Hospitals**, **Providers**, **Referral** procedures, **Complaint** procedures, and emergency coverage provisions.

The law requires the carrier to make its access plans (except for certain confidential information, as specified in section 24-72-204 (3) of the Colorado Revised Statutes) available on its business premises and to provide them to any interested party upon request. To obtain additional information regarding our Colorado access plan(s), please call Customer Service at the telephone number shown on **Member's** ID card.

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:

   - the legal spouse of a **Subscriber** under this **Certificate**; or
   - child of any age who is not capable of self-support due to mental or physical incapacity.
   - a dependent child (including natural, 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.
   - a designated beneficiary, if the **Contract Holder** elects to provide coverage for designated beneficiaries as dependents. The **Subscriber** must file a notarized "Designated Beneficiary Agreement" with the County Clerk and Recorder in the county in which one of the parties reside. A designated beneficiary agreement that is properly executed and recorded shall be valid and legally enforceable in the absence of a superseding legal document that conflicts with the provision specified in the designated beneficiary agreement.

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 Care** 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.

Newly Eligible Individuals and Eligible Dependents.

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

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**.

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 payment of a specific **Premium** is required to provide coverage for a covered child, the **Subscriber** must notify **HMO** of the birth of the newborn child and payment of the required **Premium** must be furnished to **HMO** 31 days after the date of birth in order to have the coverage continue beyond the 31day period.

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. If payment of a specific **Premium** is required to provide coverage for a covered child, the **Subscriber** must notify **HMO** of the adoption and payment of the required **Premium** must be furnished to **HMO** within 31 days of the date the child is adopted or placed with the **Subscriber** for adoption.

Special Rules Which Apply to Children.

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.

Notification of Change in Status.

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

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 the following requirements are met:

- 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**;

- the eligible individual or eligible dependent previously declined coverage in writing under **HMO**;

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

- 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:

    a. 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

    b. 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.

    c. 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 includesthe following:

    - a loss of coverage as a result of legal separation, divorce or death;
    - terrmination of employment;
    - reduction 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. If the dependent becomes enrolled in the Children's Basic Health Plan, the **Contract Holder** shall notify **HMO** of the change in coverage at least 30 days before the date the dependent is no longer covered under this plan
    - 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

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

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

- 60 days, beginning on the date the eligible individual or eligible dependent

  a. becomes eligible for premium assistance in connection with coverage under **HMO**, or

  b. is no longer qualified for coverage under Medicaid; or

- 90 days, beginning on the date the eligible individual or eligible dependent is no longer qualified for coverage under S-Chip.

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

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

If the **Contract Holder** elects to cover designated beneficiaries, a designated beneficiary may also qualify for a Special Enrollment Period if you acquire a dependent through a designated beneficiary agreement. Enrollment must be requested within 30 days after becoming such a dependent. Coverage will be effective the date the person becomes 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 **Contract Holder** Termination section of the **Group Agreement** and the *Termination of Coverage* section of this **Certificate**.

Hospital Confinement on **Effective Date of Coverage**.

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

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** ID 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.

Primary Care Physician Benefits. (PCP)

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 and preventive child health supervision services for children from birth to 13 years of age.

      The Immunization Schedules published by Centers for Disease Control and Prevention shall mean the Childhood Schedule, the Adolescent and Teen Schedule, and the Adult Schedule as exists on the effective date of this regulation. This does not include later amendments to or editions of the Immunization Schedules. A copy of the Immunization Schedules may be examined during regular business hours at:

Colorado Division of Insurance

1560 Broadway, Suite 850,

Denver, Colorado, 80202.

A Certified copy of the Immunization Schedules may be requested from the Center for Disease Control and Prevention (www.cdc.gov). A charge for certification or copies may apply.

Child health supervision services which are rendered during a periodic review shall only be covered to the extent that services are provided by or under the supervision of a single **Physician** or other health care **Provider** during the course of one visit.

b. routine physical examinations;

c. routine gynecological examinations, including Pap smears, for routine care, administered by the **PCP**. The **Member** may also go directly to a **Participating** gynecologist without a **Referral** for routine GYN examinations and Pap smears. See the Direct Access Specialist Benefits section of this **Certificate** for a description of these benefits;

d. routine hearing screenings;

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

f. routine vision screenings.

6. Injections, including allergy desensitization injections.

7. Casts and dressings.

8. Health Education Counseling and Information.

Preventive Health Care Services

Covered Benefits include preventive health care services by a **Participating Provider** for the following in accordance with the A or B recommendations of the task force for the particular preventive health care service:

- Alcohol Misuse screening and behavioral counseling interventions for adults by a **PCP**;
- Cervical Cancer Screening;
- Breast cancer screening with mammography. Please refer to the Summary of Coverage for the Minimum Benefit. The minimum benefit shall be adjusted to reflect increases and decreases in the Consumer Price Index.

Please refer to the Summary of Coverage for the Maximums Visits under this section. Any subsequent mammography performed may be subject to the plan's **Deductible** or coinsurance provisions same as any other diagnostic service.

Not withstanding the A or B recommendations of the task force, an annual breast cancer screening with mammography is covered for all **Members** possessing at least one risk factor including, but not limited to:

- A family history of breast cancer;

- Being 40 years of age or older; or
- A genetic predisposition to breast cancer.

- Cholesterol Screening for Lipid Disorders;
- Colorectal Cancer Screening tests for the early detection of colorectal cancer and adenomatous polyps or a **Member** who is at a high risk for colorectal cancer including **Members** who have a family medical history of
  - colorectal cancer;
  - a prior occurrence of cancer or precursor neoplastic polyps;
  - a prior occurrence of a chronic digestive disease condition such as
    - inflammatory bowl disease;
    - Crohn's disease;
    - ulcerative colitis; or
    - other predisposing factors as determined by a **Participating Provider**.

- Influenza vaccinations pursuant to the schedule established by the Advisory Committee on Immunization Practices to the Centers for Disease Control and Prevention in the Federal Department of Health and Human Services, or any successor entity.

- Pneumococcal vaccinations pursuant to the schedule established by the Advisory Committee on Immunization Practices to the Centers for Disease Control and Prevention in the Federal Department of Health and Human Services, or any successor entity.

- Tobacco use screening of adults and tobacco cessation intervention by a **PCP**.

For purposes of this benefit, "task force", "A recommendations" and "B recommendations are defined as follows:

"A recommendations" means a recommendation adopted by the task force that strongly recommends that clinicians provide a preventive health care service because the task force found there is a high certainty that the net benefit of the preventive health care service is substantial.

"B recommendations" means a recommendation adopted by the task force that recommends that clinicians provide a preventive health care service because the task force found there is a high certainty that the net benefit is moderate or there is a moderate certainty that the net benefit is moderate to substantial.

"Task force" means the U.S. Preventive service task force, or any successor organization, sponsored by the agency for healthcare research and quality, the health service research arm of the federal department of health and human services.

The Immunization Schedules published by Centers for Disease Control and Prevention shall mean the Childhood Schedule, the Adolescent and Teen Schedule, and the Adult Schedule as exists on the effective date of this regulation. This does not include later amendments to or editions of the Immunization Schedules. A copy of the Immunization Schedules may be examined during regular business hours at:

Colorado Division of Insurance

1560 Broadway, Suite 850

Denver, Colorado, 80202.

A Certified copy of the Immunization Schedules may be requested from the Center for Disease Control and Prevention (www.cdc.gov). A charge for certification or copies may apply.

Covered Benefits shall not be subject to any applicable **Deductible** or **Coinsurance**.

Diagnostic Services Benefits.

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

1. Diagnostic, laboratory, and x-ray services.

2. Mammograms.

3. Preventive care services as follows:

    - Prostate specific antigen (PSA);
    - Digital-Rectal Exams (DRE)
    - Fecal Occult Blood Test (FOBT);
    - Sigmoidoscopies;
    - Double Contrast Barium Enemas (DCBE); and
    - Colonoscopies.

These benefits will be subject to:

- Age;
- Family history; and
- Frequency guidelines.

These guidelines will be determined by applying the most generous rules, as they apply to the **Member**. These rules are 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**.

Specialist Physician Benefits.

Covered Benefits include outpatient and inpatient services.

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

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.

- Mammography (for benefit details, please see the Preventive Health Care Services and Diagnostic Services Benefits provisions under the **Covered Benefit** section).

- Coverage is provided for non-routine eye examination, diagnosis and treatment of conditions and diseases of the eye and related eye structures. A **Referral** from the **Member's PCP** is required for inpatient **Hospital** or surgical services.

- 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.

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 **Service Area** unless the **Member** receives pre-authorization from **HMO**. As with any other medical condition, **Emergency Care** is covered when **Medically Necessary**.

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

1. a minimum of 48 hours of inpatient care in a **Participating Hospital** following a vaginal delivery;

2. a minimum of 96 hours of inpatient care in a **Participating Hospital** following a cesarean section; or

3. a shorter **Hospital** stay, if requested by a mother, and if determined to be medically appropriate by the **Participating Providers** in consultation with the mother.

    If a **Member** requests a shorter **Hospital** stay, the **Member** will be covered for 1 home health care visit scheduled to occur within 24 hours of discharge. An additional visit will

be covered when prescribed by the **Participating Provider**. This benefit is in addition to the home health maximum number of visits, if any, shown on the Schedule of Benefits. A **Copayment** will not apply for home health care visits.

Inpatient Hospital and Skilled Nursing Facility Benefits.

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

Transplants Benefits.

Once it has been determined that a **Member** may require a **Transplant**, the **Member** or the **Member's Physician** must call the **HMO** precertification department to coordinate the **Transplant** process. Non-experimental or non-investigational **Transplants** coordinated by **HMO** and performed at an **Institute of Excellence, (IOE)**, are **Covered Benefits**. The **IOE** facility must be specifically approved and designated by **HMO** to perform the **Transplant** required by the **Member**.

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

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

Any **Copayments** or **Coinsurance** associated with **Transplants** are set forth in the Schedule of Benefits. **Copayments** or **Coinsurance** apply per **Transplant Occurrence**.

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

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

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

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

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

- Autologous Blood/Bone Marrow **Transplant** followed by Allogenic Blood/Bone Marrow **Transplant** (when not part of a tandem **Transplant**)
- Allogenic Blood/Bone Marrow **Transplant** followed by an Autologous Blood/Bone Marrow **Transplant** (when not part of a tandem **Transplant**)
- Re-**Transplant** after 365 days of the first **Transplant**
- Pancreas **Transplant** following a kidney **Transplant**
- A **Transplant** necessitated by an additional organ failure during the original **Transplant Surgery**/process.
- More than one **Transplant** when not performed as part of a planned tandem or sequential **Transplant,** (e.g. a liver **Transplant** with subsequent heart **Transplant**).

Outpatient Surgery Benefits.

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

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 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.

Mental Disorders Benefits.

A **Member** is covered treatment of **Mental Disorder** 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 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.

Emergency Care/Urgent Care Benefits.

Emergency Care:

A **Member** is covered for **Emergency Care**, provided the service is a **Covered Benefit**, and **HMO's** review determines that a **Medical Emergency** existed as determined in accordance with the prudent layperson requirement imposed by law at the time medical attention was sought by the **Member**. **IN A MEDICAL EMERGENCY A MEMBER MAY CALL 911 OR ITS LOCAL MEDICAL EMERGENCY EQUIVALENT.**

The **Copayment** for an emergency room visit as described on the Schedule of Benefits will not apply either in the event that the **Member** was referred for such visit by the

Member's PCP for services that should have been rendered in the **PCP's** office or if the **Member** is admitted into the **Hospital**.

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

Medical transportation is covered during a **Medical Emergency**.

Urgent Care:

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

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

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, 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 functions.

b. Physical therapy is covered for non-chronic conditions and acute illnesses and injuries; except that coverage of physical therapy for congenital defects and birth abnormalities in **Covered Dependent**s from age 3 up to 6 years of age is without regard to whether the condition is acute or chronic. Coverage is subject to the limits, if any, shown on the Schedule of Benefits or Rehabilitation Therapies for Congenital Defects and Birth Abnormalities **Covered Benefits** provision.

c. Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute illnesses; except that coverage of occupational therapy for congenital defects and birth abnormalities in **Covered Dependents** from age 3 up to 6 years of age is without regard to whether the condition is acute or chronic. Coverage is subject to the limits, if any, shown on the Schedule of Benefits or Rehabilitation Therapies for Congenital Defects and Birth Abnormalities **Covered Benefits** provision.

d. 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; except that coverage of speech therapy for congenital defects and birth abnormalities in **Covered Dependents** from age 3 up to 6 years of age is without regard to whether the condition is acute or chronic. Coverage is subject to the limits, if any, shown on the Schedule of Benefits or Rehabilitation Therapies for Congenital Defects and Birth Abnormalities **Covered Benefits** provision.

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**.

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 or licensed nurse.

2. Certified and licensed nurse aide services. These services are covered only when the purpose of the treatment is **Skilled Care**.

3. Social Work Practice services by a licensed social worker.

4. Short-term physical, speech therapy and language therapy, respiratory and inhalation therapy, nutrition counseling or occupational therapy is covered. Services are subject to the limitations listed in the Rehabilitation Benefits section of this **Certificate**.

5. Medical supplies, equipment and appliances suitable for use in the home.

Food services or meals other than dietary counseling, excluding tube feedings, are not considered as eligible expenses under home health care benefits.

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

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;
- **Physician**;
- certified nurses aid;
- pastoral counseling;
- trained volunteer;
- psychosocial services,
- bereavement counseling;
- 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:

- funeral arrangements;
- financial or legal counseling;
- Homemaker or caretaker services; and
- any service not solely related to the care of the **Member.** This includes but is not limited to:
  - sitter or companion services for the **Member** or other **Members** of the family;
  - transportation;
  - house cleaning; and
  - maintenance of the house.

The maximum benefit for bereavement support services for the family of the deceased person during the 12 months following death shall not exceed $1,400.

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**. Coverage includes repair and replacement when due to congenital growth, repairs and replacements of prosthetic arms and legs 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.

Reconstructive Breast Surgery Benefits.

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

Diabetic Supplies and Equipment.

Subject to payment of the applicable **Copayment**, the following equipment, supplies and education services for the treatment of

- insulin treated diabetes;
- non-insulin treated diabetes; and
- gestational diabetes conditions

are covered when **Medically Necessary** and when prescribed or ordered by a **Participating PCP** (or **Participating** nurse practitioner or clinical nurse **Specialist**) and obtained through a **Participating Provider**:

- blood glucose monitors and blood glucose monitors for the legally blind
- management systems;
- test strips for glucose monitors and/or visual reading;
- insulin;
- injection aids;
- cartridges for the legally blind;
- syringes;
- insulin pumps and appurtenances thereto;
- insulin infusion devices, oral agents for controlling blood sugar; and
- therapeutic/molded shoes for the prevention of amputation.

Coverage also includes diabetes self-management education to ensure that **Members** with diabetes are instructed as to the proper self-management and treatment of their diabetic condition, including information on the nutritional management of diabetes. Such coverage for self-management education and education relating to medical nutrition therapy shall be limited to visits **Medically Necessary** upon the diagnosis of diabetes, where a **PCP** (or **Participating** nurse practitioner or clinical nurse **Specialist**) diagnoses a significant change in the patient's symptoms or conditions which necessitate changes in a **Member's** self-management, or where re-education or refresher education is necessary. Such education, when **Medically Necessary** and prescribed by a **PCP**, must be provided only by a **PCP** or upon **Referral** to an appropriately licensed and certified health care **Provider** and may be conducted in group settings registered by a nationally recognized professional association of dietitians or a **Health Professional** recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators. Coverage for self-management education and education relating to medical nutrition therapy shall also include home visits when **Medically Necessary**.

Cervical Cancer Immunization Benefits.

Cervical Cancer Immunization is covered even though it may not be in connection with treatment of an injury or disease. It is covered only for females up to the age limitations recommended by,

and for whom a vaccination is recommended by, the Advisory Committee on Immunization Practices of the United States Department of Health and Human Services.

Clinical Trial.

A clinical trial is an experiment in which a drug or device is:

- administered to
- dispensed to; or
- used by one or more human subjects.

An experiment may include the use of a combination of drugs as well as the use of a drug in combination with an alternative therapy or dietary supplement.

Routine patient care costs are a **Covered Benefit** if:

(I) the **Member**'s treating **Physician**, who is providing covered health care services to the **Member**, recommends participation in the clinical trial after determining that participation in the clinical trial has the potential to provide a therapeutic health benefit to the **Member**;

(II) the clinical trial or study is approved under the September 19, 2000 Medical National Coverage Decision Regarding Clinical Trials, as amended;

(III) the **Member**'s care is provided by a certified, registered or licensed health care **Provider** practicing with the scope of their practice. The facility and personnel providing the treatment must have experience and training to provide the treatment in a competent manner;

(IV) prior to participation in a clinical trial or study, the **Member** has signed a statement of consent indicating that the **Member** has been informed of:

- the procedure to be undertaken;
- alternative methods of treatment; and
- the general nature and extent of the risks associated with participation in the clinical trial or study.

The **Covered Benefits** will be consistent with the coverage provided by **HMO**; and

(V) the **Member** suffers from a condition that is disabling, progressive or life-threatening.

Routine care costs include:

- all items and services that a benefit under **HMO** would be covered if the **Member** were not involved in either the experimental or the control arms of a clinical trial. This does not include the investigation item or service, itself;
- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- items and services customarily provided by the research sponsors free of charge for any enrollee in the trial;
- routine costs in clinical trials. This includes items and services that are typically provided absent a clinical trial;
- items or services required solely for the provision of the investigation items or services, the clinically appropriate monitoring of the effects of the item or service or the prevention of complications; and

- items or services needed for reasonable and necessary care arising from the provision of an investigation item or service. This includes the diagnosis or treatment of complications.

Coverage does not include:

(I) any portion of the clinical trial or study that is paid for by a government or a biotechnical, pharmaceutical or medical industry;

(II) any drug or device that is paid for by the manufacturer, distributor or **Provider** of the drug or device;

(III) extraneous expenses related to participation in the clinical trial or study. This includes, but not limited to:
- travel;
- housing; and
- other expenses that a participant or person accompanying the participant may incur;

(IV) an item or service that is provided solely to satisfy a need for data collection or analysis that is not directly related to the clinical management of the participant;

(V) costs for the management or research relating to the clinical trial or study; or

(VI) health care services, that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under **HMO**.

Additional Benefits.

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.

Subluxation Benefits.

Services by a **Participating Provider** when **Medically Necessary** and upon prior **Referral** issued by the **PCP** are covered. Services must be consistent with **HMO** guidelines for spinal manipulation to correct a muscular skeletal problem or subluxation which could be documented by diagnostic x-rays performed by an **HMO Participating** radiologist. Coverage is subject to the maximum number of visits, if any, shown on the Schedule of Benefits.

A **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**.

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, are also covered upon pre-authorization by **HMO**. Replacement, repairs and maintenance are covered only if it is demonstrated to the **HMO** that:

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

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

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

A **Copayment**, 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**.

Cleft Lip or Cleft Palate Benefits.

Benefits shall be provided for newborn children born with cleft lip, or cleft palate, or both when **Medically Necessary** and upon prior **Referral** by the **Member's PCP**. Care and treatment shall include:

1. oral and facial **Surgery**, surgical management, and follow-up care by plastic surgeons;

2. prosthetic treatment such as obturators, speech appliances, and feeding appliances;

3. orthodontic treatment;

4. prosthodontic treatment;

5. habilitative speech therapy;

6. otolaryngology treatment; and

7. audiological assessments and treatment.

Rehabilitation Therapies For Congenital Defects and Birth Abnormalities.

- Up to a maximum of 20 therapy visits per **Contract Year** for physical therapy;
- Up to a maximum of 20 therapy visits per **Contract Year** for occupational therapy; and
- Up to a maximum of 20 therapy visits per **Contract Year** for speech therapy.

Therapy visits shall be distributed as **Medically Necessary** for **Members** from age 3 up to 5 years of age. This is without regard to whether the condition is acute or chronic or whether the purpose of the therapy is to maintain or to improve functional capacity.

Dental Care - General Anesthesia.

Coverage shall be provided for general anesthesia and **Hospital** charges and for associated **Hospital** or facility charges for dental care provided to a dependent child. Such dependent child shall, in the treating dentist's opinion, satisfy 1 or more of the following criteria:

1. The child has a physical, mental, or medically compromising condition; or

2. The child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or

3. The child is an extremely uncooperative, unmanageable, anxious, or uncommunicative child or adolescent with dental needs deemed sufficiently important that dental care cannot be deferred; or

4. The child has sustained extensive orofacial and dental trauma.

Phenylketonuria Benefit.

Coverage for medical foods for home use by infants and children with inherited enzymatic disorders affecting carbohydrate, protein and fat metabolism, when prescribed by a **Participating Provider**. For purposes of this section, "medical foods" means prescription metabolic formulas and their modular counterparts obtained through a pharmacy that are specifically designated and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and for which medically standard methods of diagnosis, treatment and monitoring exist. Such formulas are specifically processed or formulated to be deficient in one or more nutrients and are to be consumed or administered internally either via tube or oral route under the direction of a **Participating Provider**. Such coverage is only required through **Participating** pharmacy providers.

Coverage to the extent **Medically Necessary** for medical foods for the treatment of any of the following inherited enzymatic disorders:

- Phenylketonuria;
- Maternal Phenylketonuria;
- Maple Syrup Urine Disease;
- Tyrosinemia;
- Homocystinuria;

- Histidinemia;
- Urea cycle Disorders;
- Hyperlysinemia;
- Glutaric Acidemias;
- Methylmalonic Acidemia; and
- Propionic Acidemia.

Hearing Aid Benefit for Minors

Covered Benefits include charges for hearing aids for a **Covered Dependent** child under the age of 18 who has a hearing loss that has been verified by a licensed **Physician** and by a licensed audiologist. The hearing aids shall be medically appropriate to meet the needs of the child according to accepted professional standard.

For purposes of this section, a "hearing aid" means amplification technology that optimizes audibility and listening skills in the environments commonly experienced by the child, including a wearable instrument or device designed to aid or compensate for impaired human wearing. "Hearing aid" shall include any parts or ear molds.

Covered Benefits shall include the purchase of the following:

- Initial hearing aids and replacement hearing aids not more frequently than every 5 years;
- A new hearing aid when alterations to the existing hearing aid can not adequately meet the needs of the child; and
- Services and supplies including, but not limited to, the initial assessment, fitting, adjustments and auditory training that is provided according to accepted professional standards.

Covered Benefits shall be subject to the same annual **Deductible** or **Copayment,** if applicable, established for all other **Covered Benefits**.

Early Intervention Services Benefits

Early Intervention Services are covered even though they may not be in connection with treatment of an injury or disease. They are covered only for a dependent child, from birth to 3 years of age, who is identified by the Part C early intervention system as eligible for services under Part C of the Individuals with Disabilities Education Act, as amended. You must submit proof of such identification.

Early Intervention Services

These are services, provided as part of an active individualized family service plan that enhances functional ability without effecting cure. They include, but are not limited to, the following:

- Speech therapy given in connection with a speech impairment resulting from a congenital abnormality, disease or injury.

- Occupational or physical therapy expected to result in significant improvement of a body function impaired by a congenital abnormality, disease, or injury.

- Assistive technology devices.

Not more than the Early Intervention Maximum, if applicable, shown in the Schedule of Benefits will be paid, including case management costs, for each dependent child per calendar year. If applicable, the Early Intervention Maximum shall increase or decrease based on the Consumer Price Index for the Denver-Boulder-Greeley metropolitan statistical area for the state fiscal year that ends in the preceding calendar year or by such additional amount to be equal to the increase by the general assembly to the annual appropriated rate to serve one child for one fiscal year in the state-funded early intervention program (if that increase is more than the consumer price index increase).

The Early Intervention Maximum, if applicable, shall not apply to rehabilitation or therapeutic services that are necessary as the result of an acute medical condition or post-surgical rehabilitation.

Coverage for early intervention services for covered children does not duplicate or replace treatment for **Autism Spectrum Disorders**. Early intervention services supplement, but do not replace, autism coverage services.

Benefit shall not be subject to any applicable **Deductible** or **Copayments** and shall not be applied to any applicable annual or lifetime maximum.

Autism Spectrum Disorder Benefits

Covered Benefits include the services and supplies **Medically Necessary** for the diagnosis and treatment, (including behavioral therapy and Applied Behavioral Analysis), of **Autism Spectrum Disorder** when ordered by a **Physician** as part of a Treatment Plan and

- The covered child is diagnosed with **Autism Spectrum Disorder**; and
- The covered expenses are incurred prior to attainment of age 19.

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.

Treatment for **Autism Spectrum Disorders** shall include habilitative or rehabilitative care, including but not limited to:

- Occupational therapy;
- Physical therapy;
- Speech therapy; or
- Any combination of these therapies.

Benefits for occupational therapy, physical therapy or speech therapy for **Autism Spectrum Disorders** are subject to the Habilitative/Rehabilitative Care maximum benefit amount, if any, shown in the Schedule of Benefits.

Coverage for Applied Behavioral Analysis for **Autism Spectrum Disorders** is subject to the maximum, if any, shown in the Schedule of Benefits.

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

Contraceptives

Covered Benefits include the following prescription contraceptives and contraceptive devices:

- Oral Contraceptives
- Diaphrams, 1 per 365 consecutive day period;
- Injectable contraceptives;
- Contraceptive patches;
- Contraceptive rings;
- Implantable contraceptives and IUDs are covered when obtained from a **Physician**. The **Physician** will provide insertion and removal of the drugs or device.

EXCLUSIONS AND LIMITATIONS

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 but not limited to:

  - provision of blood;
  - blood plasma;
  - blood derivatives;
  - synthetic blood or blood products. This does not include blood derived clotting factors;
  - the collection or storage of blood plasma;
  - the cost of receiving the services of professional blood donors;
  - apheresis; or
  - plasmapheresis.

  Only:

  - administration;
  - processing of blood;
  - processing fees; and
  - fees related to autologous blood donations are covered.

- Care for conditions that state or local laws require to be treated in a public facility, including but not limited to, mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.

- Certain **Transplant Occurrence**-related services or supplies including: treatment furnished to a donor when the **Transplant** recipient is not a **Member**; services and supplies not obtained from an **IOE**, including:

  - the harvesting or storage of organs without the expectation of immediate transplantation for an existing illness;
  - harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months of an existing illness;
  - outpatient prescription drugs not expressly related to an outpatient **Transplant Occurrence**; and
  - home infusion therapy.

- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) **Transplants** unless authorized by **HMO**.

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

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

- Court ordered services, or those required by court order as a condition of parole or probation. This exclusion shall not apply to court ordered treatment of **Substance Abuse** that is **Medically Necessary**, and rendered by a **Participating Provider**.

- **Custodial Care.**

- Dental services, including but not limited to, services related to:

  - the care;
  - filling;
  - removal or replacement of teeth 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.

- Hair analysis.

- Hearing aids. This does not apply to hearing aids provided for under the Hearing Aid Benefit for Minors provision.

- Home births.

- Home uterine activity monitoring.

- Household equipment, including but not limited to:

  - the purchase or rental of exercise cycles;
  - water purifiers;
  - hypo-allergenic pillows;
  - mattresses or waterbeds;
  - whirlpool or swimming pools;
  - exercise and massage equipment;
  - central or unit air conditioners;
  - air purifiers;
  - humidifiers;
  - dehumidifiers;
  - escalators;
  - elevators;
  - ramps;
  - stair glides;

- emergency alert equipment;
- handrails;
- heat appliances;
- improvements made to a **Member's** house or place of business; and
- adjustments made to vehicles.

- Hypnotherapy, except when pre-authorized by **HMO**.

- Implantable drugs.

- The treatment of male or female **Infertility**, including but not limited to:

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

  2. The purchase of donor eggs and any 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 but not limited to 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 but not limited to fees for laboratory tests;

  9. Any charges associated with a frozen embryo transfer, including but not limited to thawing charges;

  10. Reversal of sterilization **Surgery**; and

  11. Any charges associated with obtaining sperm for 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 but not limited to, those services and supplies:

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

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

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

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

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

- Orthotics.

- Outpatient supplies, including but not limited to, medical consumable or disposable supplies such as:

  - incontinence pads;
  - elastic stockings, and
  - reagent strips.

  This does not include for diabetic supplies as itemized in the **Covered Benefits** section.

- 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. This does not include insulin and prescription contraceptives.

- 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.

- Routine foot/hand care, including routine reduction of nails, calluses and corns.

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

- Services for the treatment of sexual dysfunctions or inadequacies, including therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.

- Services, including those related to pregnancy, rendered before the effective date or after the termination of the **Member's** coverage, unless coverage is continued under the Continuation and Conversion section of this **Certificate**.

- Services performed by a relative of a **Member** for which, in the absence of any health benefits coverage, no charge would be made.

- Services required by third parties, including but not limited to, physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state, or federal government, securing insurance coverage, travel, school admissions or attendance, including examinations required to participate in athletics, except when such examinations are considered to be part of an appropriate schedule of wellness services.

- Services which are not a **Covered Benefit** under this **Certificate**.

- Specific non-standard allergy services and supplies, including but not limited to

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

- Specific injectable drugs, including:

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

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

  3. 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.

- Therapy or rehabilitation, including but not limited to:

  - primal therapy;
  - chelation therapy;
  - rolfing;
  - psychodrama;
  - megavitamin therapy;
  - purging;
  - bioenergetic therapy;
  - vision perception training; and
  - carbon dioxide.

- Thermograms and thermography.

- Transsexual **Surgery**, sex change or transformation, including any procedure or treatment or related service designed to alter a **Member's** physical characteristics from the **Member's** biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.

- Treatment in a federal, state, or governmental entity, including care and treatment provided in a non-**Participating Hospital** owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.

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

- Treatment of occupational injuries and occupational diseases, including those injuries that arise out of (or in the course of) any work for pay or profit, or in any way results from a disease or injury which does. If a **Member** is covered under a Workers' Compensation law or similar law, and submits proof that the **Member** is not covered for a particular disease or injury under such law, that disease or injury will be considered "non-occupational" regardless of cause.

- Unauthorized services, including any service obtained by or on behalf of a **Member** without a **Referral** issued by the **Member's PCP** or pre-authorized by **HMO**. 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, except as provided in the **Covered Benefits** section or as covered in the Vision rider.

- Weight control services including:

  - **Surgical Procedures;**
  - medical treatments;
  - weight control/loss programs;
  - dietary regimens and supplements;
  - appetite suppressants and other medications;
  - food or food supplements;
  - 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.

- Acupuncture and acupuncture therapy. This does not apply when performed by a **Participating Physician** as a form of anesthesia in connection with covered **Surgery**.

- Services related to the care, filling, removal or replacement of impacted teeth.

- Temporomandibular joint disorder treatment (TMJ), including but not limited to:

  - treatment performed by prosthesis placed directly on the teeth;
  - surgical and non-surgical medical and dental services; and
  - diagnostic or therapeutics services related to TMJ.

- Family planning services.

Limitations.

- In the event there are 2 or more alternative **Medical Services** which 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 subject to the terms of this **Certificate**.

HMO's determinations, interpretations and decisions on these matters are subject to de novo review by an impartial reviewer as provided in this **Certificate** or as allowed by law. **Members** and beneficiaries are entitled to have their claims reviewed de novo in any court with jurisdiction and to a trial by jury.

TERMINATION OF COVERAGE

A **Member's** coverage under this **Certificate** will terminate upon the earliest of any of the conditions listed below and termination will be effective on the date indicated on the Schedule of Benefits.

A. **Termination of Subscriber Coverage**.

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

1. employment terminates;

2. the **Group Agreement** terminates;

3. the **Subscriber** is no longer eligible as outlined in this **Certificate** and/or on the Schedule of Benefits; or

4. the **Subscriber** becomes covered under an alternative health benefit plan or under any other plan which is offered by, through, or in connection with, the **Contract Holder** in lieu of coverage under this **Certificate**.

B. **Termination of Dependent Coverage.**

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

1. a **Covered Dependent** is no longer eligible, as outlined in this **Certificate** and/or on the Schedule of Benefits;

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

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

Coverage of a designated beneficiary as a defined dependent will end on the earlier to occur of:

- The date this plan no longer allows coverage for a designated beneficiary.
- The date the "Designated Beneficiary Agreement" is revoked by either party to the agreement by recording a revocation with the Clerk and Recorder of the County in which the agreement was recorded.

C. **Termination For Cause**.

HMO may terminate coverage for cause:

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

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

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

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

5. immediately, upon discovery of a material misrepresentation by the **Member** in applying for or obtaining coverage or benefits under this **Certificate** or upon discovery of the **Member's** commission of fraud against **HMO**. This may include, but is not limited to, furnishing incorrect or misleading information to **HMO**, or allowing or assisting a person other than the **Member** named on the identification card to obtain **HMO** benefits. **HMO** may, at its discretion, rescind a **Member's** coverage on and after the date that such misrepresentation or fraud occurred. It may also recover from the **Member** the reasonable and recognized charges for **Covered Benefits**, plus **HMO**'s cost of recovering those charges, including reasonable attorneys' fees. In the absence of fraud or material misrepresentation, all statements made by any **Member** or any person applying for coverage under this **Certificate** will be deemed representations and not warranties. No statement made for the purpose of obtaining coverage will result in the termination of coverage or reduction of benefits unless the statement is contained in writing and signed by the **Member**, and a copy of same has been furnished to the **Member** prior to termination.

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

A **Member** may register a **Complaint** with **HMO**, as described in the Complaints and Appeals, **External Review** and 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 provide the **Member** with a 30 day advance written notice prior to the date of the rescission and 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** Complaints and Appeals, **External Review**, and Dispute Resolution sections to register a **Complaint** against **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 liability or responsibility under this **Certificate** for services provided on or after the date of termination of coverage, except as provided under the Continuation and Conversion section of this **Certificate**.

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

CONTINUATION AND CONVERSION

COBRA Continuation Coverage.

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

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

1. Minimum Size of Group:

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

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

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

3. Loss of coverage due to:

   a. divorce or legal separation, or

   b. **Subscriber's** death, or

   c. **Subscriber's** entitlement to Medicare benefits, or,

   d. cessation of **Covered Dependent** child status under the Eligibility and Enrollment section of this **Certificate**:

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

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

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

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

   c. the first day on which timely payment of **Premium** is not made subject to the **Premiums** section of the **Group Agreement**.

   d. the first day on which the **Contract Holder** ceases to maintain any group health plan.

   e. the first day, after the day COBRA coverage has been elected, on which a **Member** is actually covered by any other group health plan. In the event the **Member** has a preexisting condition, and the **Member** would be denied coverage under the new plan for a preexisting condition, continuation coverage will not be terminated until the last day of the continuation period, or the date upon which the **Member's** preexisting condition becomes covered under the new plan, whichever occurs first.

   f. the date, after COBRA coverage has been elected, when the **Member** is entitled to Medicare.

5. Extensions of Coverage Periods:

   a. The 18-month coverage period may be extended if an event which would otherwise qualify the **Member** for the 36-month coverage period occurs during the 18-month period, but in no event may coverage be longer than 36 months from the event which qualified the **Member** for continuation coverage initially.

   b. In the event that a **Member** is determined, within the meaning of the Social Security Act, to be disabled and notifies the **Contract Holder** within 60 days of the Social Security determination and before the end of the initial 18-month period, continuation coverage for the **Member** and other qualified beneficiaries may be extended up to an additional 11 months for a total of 29 months. The **Member** must have become disabled during the first 60 days of the COBRA continuation coverage.

6. Responsibility of the **Contract Holder** to provide **Member** with notice of Continuation Rights:

The **Contract Holder** is responsible for providing the necessary notification to **Members**, within the defined time period, as required by COBRA.

7. Responsibility to pay **Premiums** to **HMO**:

   The **Subscriber** or **Member** will only have coverage for the 60-day initial enrollment period if the **Subscriber** or **Member** pays the applicable **Premium** charges due within 45 days of submitting the application to the **Contract Holder**.

8. **Premiums** due **HMO** for the continuation of coverage under this section shall be due in accordance with the procedures of the **Premiums** section of the **Group Agreement** and shall be calculated in accordance with applicable federal law and regulations.

Continuation of Coverage under Colorado State Law. (If the Group Agreement must comply with COBRA, then that continuation right will take precedence over this continuation provision in most circumstances. See the COBRA provisions above.)

Any **Subscriber** and the **Subscriber's Covered Dependents** whose coverage under this **Group Agreement** terminates because of termination of employment or eligibility may be eligible to continue coverage. Continuation will only be available if the **Subscriber** has been continuously covered under this contract, or under any group policy providing similar benefits which this contract replaces, during the six (6) months immediately prior to the termination of employment or eligibility. This continuation privilege is available to former spouses.

Contract Holder will provide the **Subscriber** with notice of this continuation right within ten (10) days from the termination of employment or eligibility and the **Premium** amount to pay each month. Failure of timely payment by the **Subscriber** will result in loss of coverage. The **Subscriber** will have thirty (30) days from the date of termination of employment to apply for continuation of coverage. If the **Contract Holder** fails to provide notice, the **Subscriber** has sixty (60) days from the date of termination of employment to make proper payment to the **Contract Holder** to continue coverage. Timely payment and notice by the **Subscriber** will result in the continuation of coverage with no interruptions.

Coverage under this provision is subject to all of the terms and conditions of the **Group Agreement**.

Continuation is not available if the Member:

1. Is covered by Medicare, Title XVIII of the federal "Social Security Act"; or Medicaid, Title XIX of the Federal "Social Security Act";

2. Is covered by any other insured or uninsured group plan that provides **Hospital**, surgical, or medical coverage and **Member** was not covered immediately before termination; or

3. Exercises the conversion privilege under this **Certificate of Coverage**.

Coverage under this provision will end on the earlier of:

1. The end of the period for which Premium was paid, if timely payment of a required **Premium** is not made;

2. Eighteen (18) months after the **Subscriber's** termination of employment or membership; or

3. The date the **Group Agreement** is terminated.

If this **Group Agreement** terminates and is not replaced by another group plan within thirty-one (31) days, the **Member** will be notified by **HMO** of the conversion privilege.

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 a:

1. **Medically Necessary** leave of absence from school; or

2. 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.

Continuation of Coverage-Reduction in Hours of Work

A **Contract Holder**, that covers full-time employees working 40 or more hours, may elect to continue coverage for such employees and their dependents, under the same conditions and for the same **Premium**, even if the **Contract Holder** reduces the working hours of such employees to less than 30 hours per week and the following conditions are met:

- The **Subscriber** is employed as a full-time employee of the **Contract Holder** and is covered under the **Group Agreement**, or under any group policy providing similar benefits, immediately prior to such reduction in working hours;
- The **Contract Holder** has imposed a reduction in working hours due to economic conditions or the reduction of hours is due to the **Subscriber**'s injury, disability or chronic health conditions; and
- The Contract Holder intends to restore the **Subscriber** to a full 40 hour work schedule as soon as economic conditions improve or as soon as the **Subscriber** is able to return to full-time work.

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 for any reason other than non payment of **Premium**, fraud or abuse 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.

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.

Extension of Benefits Upon Total Disability.

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

This extension of benefits shall only:

1. provide **Covered Benefits** that are necessary to treat medical conditions causing or directly related to the disability as determined by **HMO**; and

2. remain in effect until the earlier of the date that:

    a. the **Member** is no longer **Totally Disabled**;

    b. the **Member** has exhausted the **Covered Benefits** available for treatment of that condition;

c. the **Member** has become eligible for coverage from another health benefit plan which does not exclude coverage for the disabling condition; or

d. after a period of 12 months in which benefits under such coverage are provided to the **Member**.

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

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.

In the event a **Colorado Small Employer Health Plan** terminates coverage for the group, the **HMO** is responsible for giving notice of the conversion privilege.

Otherwise conversion notification is not initiated by **HMO**. The conversion privilege set forth in this subsection must be initiated by the eligible **Member**. The **Contract Holder** is responsible for giving notice of the conversion privilege in accordance with its normal procedures; however, in the event continuation coverage ceases pursuant to expiration of COBRA benefits as described in the COBRA Continuation Coverage section of this **Certificate**, the **Contract Holder** shall notify the **Member** at some time during the 180-day period prior to the expiration of coverage.

1. Eligibility.

In the event a **Member** ceases to be eligible for coverage under this **Certificate** and has been continuously enrolled for 3 months under **HMO**, such person may, within 31 days after termination of coverage under this **Certificate**, convert to individual coverage with **HMO**, effective as of the date of such termination, without evidence of insurability provided that **Member's** coverage under this **Certificate** terminated for 1 of the following reasons:

a. coverage under this **Certificate** was terminated, and was not replaced with continuous and similar coverage by the **Contract Holder**; or

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; or

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 or Colorado State Continuation Coverage section of this **Certificate**.

Any **Member** who is eligible to convert to individual coverage, may do so in accordance with the rules and regulations governing items such as initial payment, the form of the agreement and all terms and conditions thereunder as **HMO** may have in effect at the time of **Member's** application for conversion, without furnishing evidence of insurability. The conversion coverage will provide benefits no less than what is then required by, and no benefits contrary to, any applicable law or regulation. However, the

conversion coverage may not provide the same coverage, and may be less than what is provided under the **Group Agreement**. Upon request, **HMO** or the **Contract Holder** will furnish details about conversion coverage.

2. A spouse has the right to convert when coverage is terminated for any reason (subject to the ability of minors to be bound by contract), except upon:

   a. Termination of coverage with respect to **Member's** or **Covered Dependent's** eligible class; or

   b. Failure of the **Subscriber** to make any required payments.

   c. Termination of the Group Agreement. (Does not apply to **Colorado Small Employer Health Plan** except if group policy replacement, fraud or abuse.)

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

CLAIM PROCEDURES/COMPLAINTS AND APPEALS

CLAIM PROCEDURES

A claim occurs whenever a **Member** or the **Member's** authorized representative requests pre-authorization as required by the plan from **HMO**, a **Referral** as required by the plan from a **Participating Provider** or requests payment for services or treatment received. As an **HMO Member**, most claims do not require forms to be submitted. However, if a **Member** receives a bill for **Covered Benefits**, the bill must be submitted promptly to the **HMO** for payment. Send the itemized bill for payment with the **Member's** identification number clearly marked to the address shown on the **Member's** ID card.

HMO will make a decision on the **Member's** claim. Notice of the benefit determination on the claim will be provided to the **Member** within the below timeframes. Under certain circumstances, these time frames may be extended. If **HMO** makes an adverse benefit determination, notice will be provided in writing to the **Member**, or in the case of a concurrent care claim, to the **Participating Provider**. The notice will provide important information about making an **Appeal** of the adverse benefit determination. Please see the **Certificate** for more information about **Appeals**.

"Adverse benefit determinations" are decisions made by **HMO** that result in denial, reduction, or termination of a benefit or the amount paid for it. It also means a decision not to provide a benefit or service or termination of a **Member's** coverage back to the original effective date (rescission). Such adverse benefit determination may be based on:

- Your eligibility for coverage.
- Coverage determinations, including plan limitations or exclusions; except when the **Member** presents evidence from a medical professional that there is a reasonable medical basis that the exclusion does not apply to the denied benefit.
- The results of any Utilization Review activities.
- A decision that the service or supply is an **Experimental or Investigational Procedure**.
- A decision that the service or supply is not **Medically Necessary**.

A “final adverse benefit determination” is an adverse benefit determination that has been upheld by **HMO** at the exhaustion of the **Appeals** process.

HMO Timeframe for Notification of a Benefit Determination

Type of Claim	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

As to a Concurrent Care Claim Reduction or Termination, if the **Member** files an **Appeal**, **Covered Benefits** under the **Certificate** will continue for the previously approved course of treatment until a final **Appeal** decision is rendered. During this continuation period, the **Member** is responsible for any **Copayments** and **Deductibles** that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under **Appeal**. If **HMO's** initial claim decision is upheld in the final **Appeal** decision, the **Member** will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.

COMPLAINTS AND APPEALS

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

- **Appeal.** An **Appeal** is a request to the **HMO** to reconsider an adverse benefit determination. The **Appeal** procedure for an adverse benefit determination has one; two level(s).

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

- **External Review.** A review of an adverse benefit determination or a final adverse benefit determination by an Independent Review Organization/External Review Organization (ERO) assigned by the State Insurance Commissioner that is Federally approved made up of **Physicians**

or other appropriate **Providers**. The ERO must have expertise in the problem or question involved.

A. **Complaints**.

If the **Member** is dissatisfied with the administrative services the **Member** receives from the **HMO** or wants to complain about a **Participating Provider,** call or write Member Services 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. **Peer-to-Peer Conversation**

For a pre-service claim determination, the **Participating Provider** rendering the service may request, orally or in writing on the **Member**'s behalf, a conversation between the **Participating Provider** and the **HMO** regarding the **HMO**'s adverse benefit determination. This conversation will take place within 5 calendar days of the **HMO**'s receipt of the request. If this conversation does not resolve the issue to the **Participating Provider**'s and **Member**'s satisfaction, the adverse benefit determination may be appealed as stated in Section D below.

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

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

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

D. Appeals of Adverse Benefit Determinations.

The **Member** will receive written notice of an adverse benefit determination from the **HMO**. The notice will include the reason for the decision and it will explain what steps must be taken if the **Member** wishes to **Appeal.** The notice will also identify the **Member's** rights to receive additional information that may be relevant to an **Appeal**. Requests for an **Appeal** must be made in writing within 180 calendar days from the date of the notice, or after the notification of a benefit denied due to a contractual exclusion except a request for a Level One **Appeal** of an **Urgent Care** claim may also be oral.

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**.

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

The **HMO** provides for two level(s) of **Appeal** of the adverse benefit determination. The First Level **Appeal** shall be evaluated by a **Physician** who shall consult with an appropriate clinical peer or peers, unless the reviewing **Physician** is a clinical peer. The **Physician** and clinical peers shall not have been involved in the initial adverse benefit determination. A person who was previously involved with the denial may answer questions. All written denials of requests for **Covered Benefits** on the ground that such benefits are not **Medically Necessary**, appropriate, effective, or efficient shall be signed by a licensed **Physician** familiar with standards of care in Colorado.

If the **HMO** upholds an adverse benefit determination at the first level of **Appeal**, and the reason for the adverse determination was based on **Medical Necessity**, or **Experimental or Investigational** reasons, or a contractual exclusion and the **Member** presents evidence for a medical professional that there is a reasonable medical basis that the exclusion does not apply to the denied benefit, the Member or his/her authorized representative have the right to pursue an **Appeal** to an independent utilization review organization (IURO), or file the voluntary Level Two **Appeal**.

The **Member** must complete all steps in the **HMO Appeals** process before bringing a lawsuit against the **HMO**. A final adverse benefit determination notice will provide an option to request an **External Review**. 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 at the conclusion of the Level One **Appeal** explaining the **Member's** right to make a Level Two **Appeal**. Any **Member** or **Provider** acting on behalf of a **Member** with the **Member's** consent, who is dissatisfied with the results of a Level One **Appeal**, shall have the opportunity to pursue their **Appeal** before a panel of **Physicians** and/or other health care professionals with appropriate expertise who have not been involved in the **Appeal** and who has no direct financial interest in the **Appeal** or outcome of the review. The **Member** and/or an authorized representative may attend the Level Two **Appeal** hearing, question the representatives of the **HMO** and present their case and any additional information the **Member** wishes. Upon request, the **Member** and the **HMO** shall provide each other with any additional information that will be presented at the review. The information must be provided to both parties at least 5 days prior to the review. If new information becomes available after that 5 day period, such information may be presented as soon as possible.

Within 10 business days of receipt of a Level Two **Appeal**, the **HMO** will acknowledge the **Appeal** in writing.

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

HMO Timeframe for Responding to an Adverse Benefit Determination Appeal

Type of Claim	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; for persons with a physical or mental disability, create an imminent and substantial limitation on their existing ablity to live independently; or, the opinion of the **Physician** with knowledge of the **Member**'s medical condition would subject the **Member** to severe pain that cannot be adequately managed without the requested care or treatment.	Within 24 hours Review provided by Medical Director (when clinical peer) or the Medical Director in consultation with clinical peer **HMO** personnel not involved in making the adverse benefit determination.	Within 24 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 Medical Director (when clinical peer) or the Medical Director in consultation with clinical peer 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 Medical Director (when clinical peer) or the Medical Director in consultation with clinical peer **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.

E. **Exhaustion of Process.**

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

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

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

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

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

Important Note:

If **HMO** does not adhere to all claim determination and **Appeal** requirements of the Federal Department of Health and Human Services, the **Member** is considered to have exhausted the **Appeal** requirements and may proceed with **External Review** or any of the actions mentioned above.

F. **Record Retention.**

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

G. **Fees and Costs.**

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

EXTERNAL REVIEW

The **Member** may receive an adverse benefit determination or final adverse benefit determination notice because **HMO** determines that:

- the service or supply is not **Medically Necessary**;
- the service or supply is an **Experimental or Investigational Procedure**;.

In these situations, **Members** may request an **External Review** if the **Member** or the **Member's Provider** disagrees with **HMO's** decision.

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

- the **Member** received an adverse benefit determination notice by **HMO**, and **HMO** did not adhere to all claim determination and appeal requirements of the Federal Department of Health and Human services.
- the **Member** has received a final adverse benefit determination notice of the denial of a claim by **HMO**.

- the **Member's** claim was denied because **HMO** determined that the care was not **Medically Necessary** or was an **Experimental or Investigational Procedure**.
- the **Member** qualifies for an faster review as explained below.

HMO's notice of adverse benefit determination or final adverse benefit determination describes the process to follow if the **Member** wishes to pursue an **External Review** and includes a copy of the *Request for External Review Form*.

The **Member** must submit the *Request for External Review Form* to **HMO** within 123 calendar days of the date the **Member** received the adverse benefit determination or final adverse benefit determination notice. The **Member** also must include a copy of the notice and all other pertinent information that supports their request.

HMO will contact the ERO that will conduct the review of the **Member's** claim. The ERO will select one or more independent clinical reviewers with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that the **Member** sends along with the *Request for External Review Form*, and will follow **HMO's** contractual documents and plan criteria governing the benefits. The **Member** will be notified of the decision of the ERO usually within 45 calendar days of **HMO's** receipt of the **Member's** request form and all the necessary information.

A faster review is possible if the **Member's Physician** certifies (by telephone or on a separate *Request for External Review Form*) that a delay in receiving the service would:

- seriously jeopardize the **Member's** life or health; or
- jeopardize the **Member's** ability to regain maximum function; or
- if the Adverse Benefit Determination relates to an **Experimental or Investigational Procedure** treatment, if the **Physician** certifies that the recommended or requested health care service, supply or treatment would be significantly less effective if not promptly initiated.

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

Faster reviews are decided within 72 hours after **HMO** receives the request.

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

The **Member** is responsible for the cost of compiling and sending the information that they wish to be reviewed by the ERO to **HMO**. **HMO** is responsible for the cost of sending this information to the ERO and for the cost of the **external review**.

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

INDEPENDENT EXTERNAL REVIEW OF BENEFIT DENIAL

Following the **Appeals** processes described above, independent external review of benefit denials is available under this **Certificate** either following receipt of the first or second level **Appeal** letters. The **Member** will be notified in writing of their right to request an external review and of the procedure for making such a request should the First or Second Level **Appeal** review result in a determination that benefits are not payable under this **Certificate**.

A **Membe**r is only eligible to request an External Review for the following:

- Medical Services or treatment which have been denied either because they were not **Medically Necessary**, were medically inappropriate; or
- because the proposed service or treatment is considered **Experimental or Investigational**; or
- for an excluded benefit for which the claimant is able to present evidence from a medical professional that there is reasonable medical basis that the contractual exclusion does not apply to the **Covered Benefit**.

A. **Request for External Review.**

1. Within 60 calendar days after the date of receipt of a notice of **HMO's** denial of First or Second Level Appeal, a **Member** or the **Member**'s designated representative may file a request for an external review with **HMO**.

2. All requests for external review shall be made in writing to **HMO** and must include a completed external review request form as specified by the Division of Insurance. A copy of such form will be provided by **HMO** following denial of Second Level Appeal.

3. A **Member** or **Member's** designated representative requesting an expedited external review must include a request for an expedited review in the written request described below.

4. All requests for external review shall include a signed consent, authorizing **HMO** to disclose protected health information, including medical records, concerning the **Member** that is pertinent to the external review.

5. A request for external review submitted by the **Member** or the **Member's** designated representative may include new information, if significantly different from information provided or considered during the internal review process, for consideration by **HMO** and the independent external review entity.

B. **Standard External Review.**

1. Except as provided in Paragraph (2) of this Subsection B, **HMO**, upon receipt of a complete request for an external review pursuant to the process under Request for External Review above, shall deliver a copy of the request to the Commissioner of Insurance ("commissioner") within 2 working days.

2. If **HMO**, before the expiration of the deadline for sending notification to the commissioner, reverses its final **Adverse Determination** based on new information submitted by the **Member** or the **Member's** designated representative pursuant to the process under Request for External Review above, **HMO** must notify the **Member** or the **Member's** designated representative within one working day of its reversal, electronically, by facsimile, or by telephone, followed by a written confirmation.

3. Within 2 working days from the time a request for external review is received from **HMO**, the commissioner shall assign an independent external review entity to conduct the external review that has been approved pursuant to Colorado regulation. The commissioner shall randomly select an independent external review entity that does not have a conflict of interest. Upon assignment, the commissioner shall notify **HMO**, electronically, by facsimile, or by telephone, followed by a written confirmation, of the name and address of the independent external review entity to which the appeal should be sent.

4. After receipt of notice from the commissioner, **HMO** shall notify within 2 working days the **Member** or the **Member's** designated representative, electronically, by facsimile, or by telephone, followed by a written confirmation. The notice shall include a written description of the independent external review entity that the commissioner has selected to conduct the external review and information regarding how the **Member** or the **Member's** designated representative may provide the commissioner with documentation regarding any potential conflict of interest of the independent external review entity as described in Colorado regulation.

5. Within 2 working days of receipt of notice from **HMO**, the **Member** or the **Member's** designated representative may provide the commissioner with documentation regarding a potential conflict of interest of the independent external review entity, electronically, by facsimile, or by telephone, followed by a written confirmation. If the commissioner determines that the independent external review entity presents a conflict of interest as described in §10-16-113.5(4)(b), C.R.S., the commissioner shall assign, within 1 working day, another independent external review entity to conduct the external review. Upon this reassignment, the commissioner shall notify **HMO**, electronically, by facsimile, or by telephone, followed by a written confirmation, of the name and address of the new independent external review entity to which the appeal should be sent. The commissioner will notify the **Member** or the **Member's** designated representative in writing of the commissioner's determination regarding the potential conflict of interest and the name and address of the new independent external review entity, if applicable.

6. In reaching a decision, the assigned independent external review entity is not bound by any decisions or conclusions reached during **HMO's** utilization review process or **HMO's** internal appeal process.

7. Within 6 working days from the date **HMO** receives notice from the commissioner, **HMO** shall deliver to the assigned independent external review entity the following documents and information considered in making **HMO's** final **Adverse Determination** including:

   a. any and all information submitted to **HMO** by a **Health Care Professional** or the **Member** or **Member's** designated representative in support of the request for coverage under the **Certificate**;

   b. any and all information used by the **HMO** during the internal **Appeal** process to determine the **Medical Necessity**, medical appropriateness, medical effectiveness, or medical efficiency of the proposed treatment or service, including medical and scientific evidence and clinical review criteria;

   c. a copy of any and all denial letters issued by the **HMO** concerning the case under review;

   d. a copy of the signed consent form, authorizing **HMO** to disclose protected health information, including medical records, concerning the **Member** that is pertinent to the external review; and

   e. an index of all submitted documents.

8. Within 2 working days of receipt of the material specified in Subsection B.7 above, the independent external review entity shall deliver to the **Member** or the **Member's** designated representative the index of all materials that the **HMO** has submitted to the independent external review entity. **HMO** shall provide to the **Member** or **Member's** designated representative, upon request, all relevant information supplied to the

independent external review entity that is not confidential or privileged under state or federal law concerning the case under review.

a. The certified independent external review entity shall notify the **Member** or the **Member's** designated representative, the **Health Care Professional** of the **Member**, and **HMO** of any additional medical information required to conduct the review after receipt of the documentation required pursuant to Subsection B.7. Within 5 working days of such a request, the **Member** or the **Member's** designated representative or the **Health Care Professional** of the **Member** shall submit the additional information, or an explanation of why the additional information is not being submitted to the certified independent external review entity and **HMO**.

b. If the **Member** or **Member's** designated representative or the **Health Care Professional** of the **Member** fails to provide the additional information or the explanation of why additional information is not being submitted within the timeframe specified the assigned independent external review entity shall make a decision based on the information submitted by **HMO**.

9. If **HMO** fails to provide the required documents and information within the time specified the assigned independent external review entity may terminate the external review and make a decision to reverse **HMO's** final **Adverse Determination**.

Immediately upon the reversal the independent external review entity shall notify the **Member**, if applicable, the **Member's** designated representative, **HMO**, and the commissioner.

10. Except as provided in Subsection B.9 failure by **HMO** to provide the documents and information within the time specified shall not delay the conduct of the external review.

11. Upon receipt of the information permitted to be forwarded pursuant to the section on Request for External Review above, **HMO** may reconsider **HMO's** final **Adverse Determination** that is the subject of the external review. Consideration of new information by **HMO** of **HMO's** final **Adverse Determination** shall not delay or terminate the external review. The external review may only be terminated if **HMO** decides to reverse **HMO's** final **Adverse Determination** and provide coverage or payment for the health care service that is the subject of **HMO's** final **Adverse Determination**.

a. Within 1 working day of making the decision to reverse **HMO's** final **Adverse Determination**, **HMO** shall notify the **Member** or the **Member's** designated representative, the assigned independent external review entity, and the commissioner of its decision. The notification may be made electronically, by facsimile, or by telephone followed by a written confirmation.

b. The assigned independent external review entity shall end the external review upon receipt of the notice from **HMO**.

12. In addition to the documents and information provided to the assigned independent external review entity, the assigned independent external review entity, to the extent the documents or information are available, shall review the following:

- The **Member**'s medical records.
- The attending **Health Care Professional's** recommendation.

- Consulting reports from appropriate **Health Care Professionals** and other documents submitted by **HMO**, **Member**, the **Member's** authorized representative, or the **Member**'s treating provider.

- Any applicable clinical review criteria developed and used by **HMO**.

- Medical and scientific evidence determined to be relevant and appropriate by the independent review entity.

The independent external review entity shall base its determination on an objective review of relevant medical and scientific evidence.

13. Except as provided in Section 13.b, within 30 working days after the date of receipt of the request for external review by **HMO**, the assigned independent external review entity shall provide written notice of its decision to uphold or reverse **HMO's** final **Adverse Determination** to:

    a. **Member**; if applicable, the **Member**'s designated representative; **HMO**; the **Physician** or other **Health Care Professional** of the **Member**; and the commissioner.

    b. The expert reviewer may request that the commissioner extend the deadline for the written notice of the independent external review entity up to 10 working days for the consideration of additional information required pursuant to Section B.8.

    c. In addition to the requirements of Colorado statute, the independent external review entity shall include in the notice.

        i. The date the independent external review entity received the assignment from the commissioner to conduct the external review;

        ii. The date of its decision; and

        iii. An explanation that the external review decision is the final appeal available to the consumer under state insurance law.

    d. Upon **HMO's** receipt of the independent external review entity's notice of a decision reversing **HMO's** final **Adverse Determination**, **HMO** shall approve the coverage that was the subject of **HMO's** final **Adverse Determination**. For concurrent and prospective reviews, **HMO** shall approve the coverage within 1 working day. For retrospective reviews, **HMO** shall approve the coverage within 5 working days. **HMO** shall provide written notice of the approval to the **Member** or the **Member's** designated representative within 1 working day of **HMO's** approval of coverage. The coverage shall be provided subject to the terms and conditions applicable to benefits under the **Certificate**.

C. **Expedited External Review.**

1. Except as provided in Section C.14 of this Expedited External Review section, a **Member** or the **Member**'s designated representative may make a request for an expedited external review with **HMO** if the **Member** has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the **Member**, would jeopardize the **Member's** ability to regain maximum function or, for persons with a disability, create an imminent and substantial limitation of their existing ability to live independently.

2. The **Member**'s or the **Member's** designated representative's request for an expedited review must include a physician's certification that the **Member's** medical condition meets the criteria in Section C.1 above.

3. Upon receipt of a request for an expedited external review, **HMO** shall notify and send a copy of the request to the commissioner within 1 working day it will be sent electronically or by telephone or facsimile or any other available expeditious method.

4. Within 1 working day of the time the commissioner receives a request for an expedited external review, the commissioner shall randomly assign an independent external review entity that has been approved pursuant to Colorado regulation to conduct the review and to make a decision regarding **HMO's** final **Adverse Determination**. The commissioner shall select an independent external review entity that does not have a conflict of interest with the case, as described in Colorado regulation. Upon assignment, the commissioner shall inform **HMO** of the name and address of the independent external review entity to which the appeal should be sent.

5. Within 1 working day of notice from the commissioner, **HMO** shall notify the **Member** or **Member's** designated representative, electronically, by facsimile, or by telephone followed by a written confirmation. The notice shall include a written description of the independent external review entity that the commissioner has selected to conduct the independent review.

   In reaching a decision, the assigned independent external review entity is not bound by any decisions or conclusions reached during **HMO's** utilization review process or **HMO's** internal appeal process as set forth in Colorado insurance regulation.

6. Within 3 working days of the time **HMO** receives the request, **HMO** shall provide or transmit all necessary documents and information, as described in Standard External Review above, considered in making **HMO's** final **Adverse Determination** to the assigned independent external review entity electronically or by telephone or facsimile or any other available expeditious method.

7. Within 1 working day of receiving documents and information, the independent external review entity shall deliver to the **Member** or the **Member's** designated representative an index of all materials that the **HMO** has submitted to the independent external review entity. **HMO** shall provide to the **Member** or **Member's** designated representative, upon request, all information supplied to the independent external review entity that is not confidential or privileged under state or federal law concerning the case under review.

8. The certified independent external review entity shall notify, electronically, by facsimile, or by telephone followed by a written confirmation, the **Member** or **Member's** designated representative, the **Health Care Professional** of the **Member**, and **HMO** of any additional medical information required to conduct the review after receipt of the documentation required. The **Member** or **Member's** designated representative or the **Health Care Professional** of the **Member** shall submit the additional information, or an explanation of why the additional information is not being submitted to the certified independent external review entity and **HMO** within 2 working days of such a request.

9. In addition to the documents and information provided or sent to the assigned independent external review entity, the assigned independent external review entity, to the extent the information or documents are available, shall consider the following in reaching a decision:

   - The **Member's** medical records.

- The attending **Health Care Professional's** recommendation.
- Consulting reports from appropriate **Health Care Professionals** and other documents submitted by **HMO**, **Member**, the **Member's** authorized representative, or the **Member**'s treating **Provider**.
- Any applicable clinical review criteria developed and used by **HMO**.
- Documents and information regarding medical and scientific evidence, to the extent the independent review entity considers them appropriate.

The independent external review entity shall base its determination on an objective review of relevant medical and scientific evidence.

10. Except as provided below in Section C.11, within 7 working days after the date of receipt of the request for external review by **HMO**, the assigned independent external review entity shall:

    a. Make a decision to uphold or reverse **HMO's** final **Adverse Determination**; and

    b. Notify the **Member**, if applicable, the **Member's** designated representative, **HMO**, the **Member's** physician, and the commissioner of the decision.

11. The expert reviewer may request the commissioner to extend the deadline for the written notice of the independent external review entity up to 5 working days for the consideration of additional information of this Expedited External Review section.

12. If the notice provided was not in writing, within 2 working days after the date of providing that notice, the assigned independent external review entity shall:

    a. Provide written confirmation of the decision to the **Member**, if applicable, the **Member's** designated representative, **HMO**, and the commissioner; and

    b. Include the information set forth in section B.13.C of Standard External Review above.

13. Upon **HMO's** receipt of the independent external review entity's notice of a decision reversing **HMO's** final **Adverse Determination**, **HMO** shall approve the coverage that was the subject of **HMO's** final **Adverse Determination** within 1 working day. **HMO** shall provide written notice of the approval to the **Member** or the **Member's** designated representative within 1 working day of receipt of the notice. The coverage shall be provided subject to the terms and conditions applicable to benefits under the **Certificate**.

14. An expedited external review may not be provided for retrospective **Adverse Determinations**.

D. **Binding Nature of External Review Decision.**

1. An external review decision is binding on **HMO** and the **Member** except to the extent **HMO** and **Member** have other remedies available under federal or state law; however, the determination of the expert reviewer will create a rebuttable presumption in any subsequent action.

2. A **Member** or the **Member's** designated representative may not file a subsequent request for external review involving **HMO's** final **Adverse Determination** for which the **Member** has already received an external review decision.

COORDINATION OF BENEFITS

If a **Member** is covered by more than 1 Plan, the **Member** should file all of their claims with each Plan.

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

- **Allowable Expense(s).** 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. 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 **Hospita**l 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**. 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**.

  2. 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.

  3. The amount a benefit is reduced by the **Primary Plan** because a **Member** does not comply with the **Plan** provisions. Examples of these provisions are second surgical opinions, pre-authorization of admissions, and preferred **Provider** arrangements.

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

- **Claim Determination Period(s).** The calendar year.

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

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

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

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

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

  1. Group, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
  2. Other prepaid coverage under service plan contracts, or under group or individual practice;
  3. Uninsured arrangements of group or group-type coverage;
  4. Labor-management trusteed plans, labor organization plans, employer organization plans, or employee benefit organization plans;
  5. Medical benefits coverage in a group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts;
  6. **Medicare** or other governmental benefits;
  7. Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group.

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

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

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

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

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

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

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

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

Order of Benefit Determination.

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

A. The **Primary Plan** pays or provides its benefits as if the **Secondary Plan**(s) did not exist.

B. A **Plan** that does not contain a **COB** provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the **Plan** provided by the **Contract Holder**. Examples of this type of exception are major medical coverages that are superimposed over base plan providing **Hospital** and surgical benefits, and insurance type coverages that are written in connection with a **Closed Panel Plan** to provide out-of-network benefits.

C. A **Plan** may consider the benefits paid or provided by another **Plan** in determining its benefits only when it is secondary to that other **Plan**.

D. The first of the following rules that describes which **Plan** pays its benefits before another **Plan** is the rule which will govern:

1. **Non-Dependent or Dependent.** The **Plan** that covers the person other than as a dependent, for example as an employee, **Subscriber** or retiree is primary and the **Plan** that covers the person, as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the 2 **Plans** is reversed so that the **Plan** covering the person as an employee, **Subscriber** or retiree is secondary and the other **Plan** is primary.

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

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

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

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

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

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

- The **Plan** of the **Custodial Parent**;
- The **Plan** of the spouse of the **Custodial Parent**;

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

3. **Active or Inactive Employee.** The **Plan** that covers a person as an employee who is neither laid off nor retired, is the **Primary Plan**. The same holds true if a person is a dependent of a person covered as a retiree and an employee. If the other **Plan** does not have this rule, and if, as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. Coverage provided to an individual as a retired worker and as a dependent of an actively working spouse will be determined under this section.

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

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

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

Effect on Benefits of this Certificate .

A. When this **Plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a **Claim Determination Period** are not more than 100% of total **Allowable Expenses**. The difference between the benefit payments that this **Plan** would have paid had it been the **Primary Plan**, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the **Member** and used by this **Plan** to pay any **Allowable Expenses**, not otherwise paid during the claim determination period. As each claim is submitted, this **Plan** will:

1. Determine its obligation to pay or provide benefits under its contract;

2. Determine whether a benefit reserve has been recorded for the **Member**; and

3. Determine whether there are any unpaid **Allowable Expenses** during that **Claim Determination Period**.

B. If a **Member** is enrolled in 2 or more **Closed Panel Plans** and if, for any reason, including the provision of service by a non-panel **Provider**, benefits are not payable by 1 **Closed Panel Plan**, **COB** shall not apply between that **Plan** and other **Closed Panel Plans**.

Effect of Medicare on COB.

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

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

1. Are covered under a program;

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

3. Have terminated coverage under a program; or

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

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

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

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

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

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

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

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

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

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

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

Multiple Coverage Under This Plan.

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

- The **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**. If so, **HMO** may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under this **Certificate**. **HMO** will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery.

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

RIGHT OF RECOVERY

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

If this **Plan** provides benefits under this **Certificate** to a **Member** for expenses incurred due to Third Party injuries, then **HMO** retains the right to repayment of the full cost of all benefits provided by this **Plan** on behalf of the **Member** that are associated with the Third Party injuries. **HMO's** rights of recovery apply to any recoveries made by or on behalf of the **Member** from any sources, including but not limited to: payments made by a Third Party or any insurance company on behalf of the Third Party; any payments or awards under an uninsured or underinsured motorist coverage policy; any Workers' Compensation or disability award or settlement; medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; and any other payments from a source intended to compensate a **Member** for Third Party injuries.

By accepting benefits under this **Plan**, the **Member** specifically acknowledges **HMO's** right of recovery. When this **Plan** provides health care benefits for expenses incurred due to Third Party injuries, **HMO** shall be entitled to the **Member's** rights of recovery against any party to the extent of the full cost of all benefits provided by this **Plan**.

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

granted an assignment of the proceeds of any settlement, judgment or other payment received by the **Member** to the extent of the full cost of all benefits provided by this **Plan**. By accepting benefits under this **Plan**, the **Member** and the **Member's** representatives further agree to:

A. Notify **HMO** promptly and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to Third Party injuries sustained by the **Member**;

B. Cooperate with **HMO**, provide **HMO** with requested information, and do whatever is necessary to secure **HMO's** rights of recovery under this **Certificate**;

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

D. Pay, as the first priority, from any recovery, settlement, judgment, or other source of compensation, any and all amounts due **HMO** as reimbursement for the full cost of all benefits associated with Third Party injuries provided by this **Plan**, unless otherwise agreed to by **HMO** in writing; and

E. Do nothing to prejudice **HMO**'s rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by this **Plan**.

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

HMO may recover the full cost of all benefits provided by this **Plan** under this **Certificate** without regard to any claim of fault on the part of the **Member**, whether by comparative negligence or otherwise. In the event the **Member** or the **Member's** representative fails to cooperate with **HMO**, the **Member** shall be responsible for all benefits provided by this **Plan** in addition to costs and attorney's fees incurred by **HMO** in obtaining repayment.

RECOVERY RIGHTS RELATED TO WORKERS' COMPENSATION

If 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 as described under the Right of Recovery provision. "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** will exercise its Recovery Rights against the **Member**.

The Recovery Rights will be applied even though:

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

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

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; or

d) The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

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.

RESPONSIBILITY OF MEMBERS

A. **Members** or applicants shall complete and submit to **HMO** such application or other forms or statements as **HMO** may reasonably request. **Members** represent that all information contained in such applications, forms and statements submitted to **HMO** incident to enrollment under this **Certificate** or the administration herein shall be true, correct, and complete to the best of the **Member's** knowledge and belief.

B. The **Member** shall notify **HMO** immediately of any change of address for the **Member** or any of the **Subscriber's Covered Dependents**, unless a different notification process is agreed to between **HMO** and **Contract Holder**.

C. The **Member** understands that **HMO** is acting in reliance upon all information provided to it by the **Member** at time of enrollment and afterwards and represents that information so provided is true and accurate.

D. By electing coverage pursuant to this **Certificate**, or accepting benefits hereunder, all **Members** who are legally capable of contracting, and the legal representatives of all **Members** who are incapable of contracting, at time of enrollment and afterwards, represent that all information so provided is true and accurate and agree to all terms, conditions and provisions in this **Certificate**.

E. **Members** are subject to and shall abide by the rules and regulations of each **Provider** from which benefits are provided.

GENERAL PROVISIONS

A. **Identification Card.** The identification card issued by **HMO** to **Members** pursuant to this **Certificate** is for identification purposes only. Possession of an **HMO** identification card confers no right to services or benefits under this **Certificate**, and misuse of such identification card may be grounds for termination of **Member's** coverage pursuant to the Termination of Coverage section of this **Certificate**. If the **Member** who misuses the card is the **Subscriber**, coverage may be terminated for the **Subscriber** as well as any of the **Covered Dependents**. To be eligible for services or benefits under this **Certificate**, the holder of the card must be a **Member** on whose behalf all applicable **Premium** charges under this **Certificate** have been paid. Any person receiving services or benefits which such person is not entitled to receive pursuant to the provisions of this **Certificate** shall be charged for such services or benefits at billed charges.

If any **Member** permits the use of the **Member's HMO** identification card by any other person, such card may be retained by **HMO**, and all rights of such **Member** and their **Covered Dependents**, if any, pursuant to this **Certificate** shall be terminated immediately, subject to the Claim Procedures/Complaints and Appeals in this **Certificate**.

B. **Reports and Records. HMO** is entitled to receive from any **Provider** of services to **Members**, information reasonably necessary to administer this **Certificate** subject to all applicable confidentiality requirements as defined in the General Provisions section of this **Certificate**. By accepting coverage under this **Certificate**, the **Subscriber**, for himself or herself, and for all **Covered Dependents** covered hereunder, authorizes each and every **Provider** who renders services to a **Member** hereunder to:

1. disclose all facts pertaining to the care, treatment and physical condition of the **Member** to **HMO**, or a medical, dental, or mental **Health Professional** that **HMO** may engage to assist it in reviewing a treatment or claim;

2. render reports pertaining to the care, treatment and physical condition of the **Member** to **HMO**, or a medical, dental, or mental **Health Professional** that **HMO** may engage to assist it in reviewing a treatment or claim; and

3. permit copying of the **Member's** records by **HMO**.

C. **Refusal of Treatment.** A **Member** may, for personal reasons, refuse to accept procedures, medicines, or courses of treatment recommended by a **Participating Provider**. If the **Participating Provider** (after a second **Participating Provider's** opinion, if requested by **Member**) believes that no professionally acceptable alternative exists, and if after being so advised, **Member** still refuses to follow the recommended treatment or procedure, neither the **Participating Provider**, nor **HMO**, will have further responsibility to provide any of the benefits available under this **Certificate** for treatment of such condition or its consequences or related conditions. **HMO** will provide written notice to **Member** of a decision not to provide further benefits for a particular condition. This decision is subject to the Claim Procedures/Complaints and Appeals in this **Certificate**. Coverage for treatment of the condition involved will be resumed in the event **Member** agrees to follow the recommended treatment or procedure.

D. **Assignment of Benefits.** All rights of the **Member** to receive benefits hereunder are personal to the **Member**. Coverage may, however, be assigned by the **Member** with the written consent of **HMO**.

E. **Legal Action.** No action at law or in equity may be maintained against **HMO** for any expense or bill unless and until the appeal process has been exhausted, and in no event prior to the expiration of 60 days after written submission of claim has been furnished in accordance with requirements set forth in the **Group Agreement**. No action shall be brought after the expiration of 3 years after the time written submission of claim is required to be furnished.

F. **Independent Contractor Relationship.**

1. **Participating Providers**, non-**Participating Providers**, institutions, facilities or agencies are neither agents or employees of **HMO**. Neither **HMO** nor any **Member** of **HMO** is an agent or employee of any **Participating Provider**, non-P**articipating 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 15 days or as soon as reasonably possible of the termination of a **PCP** contract to each affected **Subscriber**, if the **Subscriber** or any **Dependent** of the **Subscriber** is currently enrolled in the **PCP's** office; and

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

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

G. **Inability to Provide Service.** If due to circumstances not within the reasonable control of **HMO**, including but not limited to, major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of the **Participating Provider** Network, the provision rendition of medical or **Hospital** benefits or other services provided under this **Certificate** is delayed or rendered impractical, **HMO** shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid **Premiums** held by **HMO** on the date such event occurs. **HMO** is required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

H. **Confidentiality.** Information contained in the medical records of **Members** and information received from any **Provider** incident to the **Provider**-patient relationship shall be kept confidential in accordance with applicable law. Information may be used or disclosed by **HMO** when necessary for a **Member's** care or treatment, the operation of **HMO** and administration of this **Certificate**, or other activities, as permitted by applicable law. For other purposes, information may be disclosed only with the consent of the **Member**. **Members** can obtain a copy of **HMO's** Notice of Information Practices by calling the Member Services toll-free telephone number listed on the **Member's** identification card.

I. **Limitation on Services.** Except in cases of **Emergency Care** or **Urgent Care**, or as otherwise provided under this **Certificate**, services are available only from **Participating Providers** and **HMO** shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a **Member** from any **Physician**, **Hospital**, **Skilled Nursing Facility**,**Home Health Care Agency**, or other person, entity, institution or organization unless prior arrangements are made by **HMO**.

J. **Incontestability.** In the absence of fraud, all statements made by a **Member** shall be considered representations and not warranties, and no statement shall be the basis for voiding coverage or denying a claim after the **Group Agreement** has been in force for 2 years from its effective date, unless the statement was material to the risk and was contained in a written application.

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

L. **Contract Holder** hereby makes **HMO** coverage available to persons who are eligible under the Eligibility and Enrollment section of this **Certificate**. However, this **Certificate** shall be subject to amendment, modification or termination in accordance with any provision hereof, by operation of law, by filing with and approval by the state Division of Insurance. This can also be done by mutual written agreement between **HMO** and **Contract Holder** without the consent of **Members**.

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

N. No agent or other person, except an authorized representative of **HMO**, has authority to waive any condition or restriction of this **Certificate**, to extend the time for making a payment, or to bind **HMO** by making any promise or representation or by giving or receiving any information. No

change in this **Certificate** shall be valid unless evidenced by an endorsement to it signed by an authorized representative of **HMO**.

O. This **Certificate**, including the Schedule of Benefits, any riders, and any amendments, endorsements, inserts, or attachments, constitutes the entire **Certificate** between the parties hereto pertaining to the subject matter hereof and supersedes all prior and contemporaneous arrangements, understandings, negotiations and discussions of the parties with respect to the subject matter hereof, whether written or oral. There are no warranties, representations, or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth in this **Certificate**. No supplement, modification or waiver of this **Certificate** shall be binding unless executed in writing by authorized representatives of the parties.

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

Q. From time to time **HMO** may offer or provide **Members** access to discounts on health care related goods or services. While **HMO** has arranged for access to these goods, services and/or third party **Provider** discounts, the third party service **Providers** are liable to the **Members** for the provision of such goods and/or services. **HMO** is not responsible for the provision of such goods and/or services nor is it liable for the failure of the provision of the same. Further, **HMO** is not liable to the **Members** for the negligent provision of such goods and/or services by third party service **Providers**. These discounts are subject to modification or discontinuance without notice.

R. **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, dentist, 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.

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:

- **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) Atypical autism as a diagnosis with Pervasive Developmental Disorder--Not Otherwise Specified.

- **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**.

- **AHIC** Aetna Health Insurance Company, Pennsylvania domiciled insurance company.

- **AHIC Benefits.** The benefits covered under the **AHIC** Group Policy and Insurance Certificate.

- **Colorado Small Employer Health Plan.** This **Plan** is considered a **Colorado Small Employer Health Plan** if it has been issued to a Small Employer (as defined below, and as determined at the time this **Plan** was issued). Small employer means any person, firm, corporation, partnership, or association that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed no more than fifty eligible employees, the majority of whom were employed within the State of Colorado and that was not formed primarily for the purpose of purchasing insurance. On and after January 1, 1996, small employer includes a business group of one as defined in Colorado Revised Statutes §10-16-102 (6)(a) and (b). In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, are considered one employer.

- **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 30 days written notice to the **Contract Holder**.

- **Cosmetic Surgery.** Any non-**Medically Necessary Surgery** or procedure whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem, but which does not restore bodily function, correct a diseased state, physical appearance, or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. **Cosmetic Surgery** includes, but is not limited to, ear piercing, rhinoplasty, lipectomy, **Surgery** for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated **Surgery**) or treatment relating to the consequences or as a result of **Cosmetic Surgery**.

- **Covered Dependent.** Any person in a **Subscriber's** family who meets all the eligibility requirements of the Eligibility and Enrollment section of this **Certificate** and the Dependent Eligibility section of the Schedule of Benefits, has enrolled in **HMO**, and is subject to **Premium** requirements set forth in the **Premiums** section of the **Group Agreement**

- **Covered Benefits.** Those **Medically Necessary Services** and supplies set forth in this **Certificate**, which are covered subject to all of the terms and conditions of the **Group Agreement** and **Certificate**. **Covered Benefits** shall include telemedicine. **Members** residing in a county with 150,000 or fewer residents. County must have the technology necessary to provide telemedicine and any health benefits provided through telemedicine must meet the same standard of care as for in-person care. Does not cover consultation provided by a **Provider** by telephone or facsimile.

- **Creditable Coverage.** Coverage of the **Member** under a group health plan (including a governmental or church plan), a health insurance coverage (either group or individual insurance), Medicare, Medicaid, a military-sponsored health care (CHAMPUS), a program of the Indian Health Service, a State health benefits risk pool, the Federal Employees Health Benefits Program (FEHBP), a public health plan, including coverage received under a plan established or maintained by a foreign country or political subdivision as well as one established and maintained by the government of the United States, any health benefit plan under section 5(e) of the Peace Corps Act and the State Children's Health Insurance Program (S-Chip). **Creditable Coverage** does not include coverage only for accident; Workers' Compensation or similar insurance; automobile medical payment insurance; coverage for on-site medical clinics; or limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits that are rovided in a separate policy.

- **Custodial Care.** Any type of care provided in accordance with Medicare guidelines, including room and board, that a) does not require the skills of technical or professional personnel; b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-**Hospital Skilled Nursing Facility** care; or c) is a level such that the **Member** has reached the maximum level of physical or mental function and such person is not likely to make further significant improvement. **Custodial Care** includes, but is not limited to, any type of care where the primary purpose of the type of care provided is to attend to the **Member's** daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of this include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non infected, post operative or chronic conditions, preparation of special diets, supervision of medication which can be self-administered by the **Member**, general maintenance care of colostomy or ileostomy, routine services to maintain other service which 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 Care.** 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., a Pennsylvania corporation licensed by the Colorado 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 Care Agency**. An agency which has been certified by the Colorado Department of Public Health and Enviroment as meeting the provisions of Title XVIII of the Federal "Social Security Act", a amended, for licensed or certified home health agencies and which is engaged in arranging and providing:
  - nursing services;
  - home health aide services; and
  - other therapeutic and related services.

- **Hospice.** A facility or service licensed by the Department of Public Health and Environment under a centrally administered program of palliative supportive, and interdisciplinary team services providing physical, psychosocial, spiritual, and bereavement care for terminally ill individuals and

their families to be available 24 hours, 7 days a week. **Hospice** services shall be provided in the home, a **Hospice** facility, and/or other licensed health facility.

- **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 agreed to admission and accepted into a **Hospice**, have a medical condition and a prognosis of less than 6 months to live. **Hospice Care** is not limited to medical intervention, but addresses:
  - physical;
  - psychosocial; and
  - spiritual needs of the patient.

- **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.

- **Infertility.** The condition of a presumably healthy **Member** who is unable to conceive or produce conception after a period of 1 year of frequent, unprotected heterosexual sexual intercourse. This does not include conditions for male **Members** when the cause is a vasectomy or orchiectomy or for female **Members** when the cause is a tubal ligation or hysterectomy.

- **Institute of Excellence™ (IOE).** One of a network of facilities specifically contracted with by **HMO** to provide certain **Transplants** to **Members**. A facility is considered a **Participating Provider** only for those types of **Transplants** for which it has been specifically contracted.

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

- **Medical Emergency.** The existence of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

- **Medical Services.** The professional services of **Health Professionals**, including medical, surgical, diagnostic, therapeutic, preventive care and birthing facility services.

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

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

- **Mental Disorders**

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.

- **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 one month, 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 Care Agency** or other recognized entity or person licensed to provide **Hospital** or **Medical Services** to **Members**.

- **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**.

- **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.

- **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 perday/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.

- **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.

- **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.

- **Specialty Care Center.** Center that is accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

- **Standing Referral.** Means a **Referral** by the **Member's PCP** to a **Participating Specialist** or **Participating Specialty Care Center** for ongoing treatment of the **Member**.

- **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.

- **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.

- **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.

- **Transplant.** Replacement of solid organs; stem cells; bone marrow or tissue.

- **Transplant Occurrence.** Considered to begin at the point of authorization for evaluation for a **Transplant**, and end: (1) 180 days from the date of the **Transplant**; or (2) upon the date the **Member** is discharged from the **Hospital** or outpatient facility for the admission or visit(s) related to the **Transplant**, whichever is later.

- **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.
6501 S. FIDDLER'S GREEN CIRCLE
SUITE 310
GREENWOOD VILLAGE, CO 80111
(COLORADO)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

- **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**.

AETNA HEALTH INC.
(COLORADO)

AMENDMENT TO THE CERTIFICATE OF COVERAGE

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

Contract Holder Group Agreement Effective Date: January 1, 2013

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

The Appeals of Adverse Benefit Determination provision appearing in the Claim Procedures/Complaints and **Appeal**s section of the **Certificate** is hereby deleted and replaced by the following:

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

The **Member** will receive written notice of an adverse benefit determination from the **HMO**. The notice will include important information including the reason for the decision and it will explain what steps must be taken if the **Member** wishes to **Appeal**. The notice will also identify the **Member**'s rights to receive additional information that may be relevant to an **Appeal**. Requests for an **Appeal** must be made in writing within 180 calendar days from the date of the notice or after the receipt of notification of a benefit denied due to a contractual exclusion except a request for a Level One **Appeal** of an urgent care claim may also be oral.

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 **HMO** upholds an Adverse Benefit Determination at the First Level of **Appeal**, and the reason for the adverse determination was based on **Medical Necessity**, or experimental or investigational reasons, or a contractual exclusion and the **Member** presents evidence for a medical professional that there is a reasonable medical basis that the exclusion does not apply to the denied benefit, the **Member** or his/her authorized representative have the right to pursue an **Appeal** to an independent utilization review organization (IURO), or file the voluntary Level Two **Appeal**. 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 **HMO**'s notice at the conclusion of the Level One **Appeal** explaining the **Member**'s right to make a Level Two **Appeal**. Any **Member** or **Provider** acting on behalf of a **Member** with the **Member's** consent, who is dissatisfied with the results of a Level One **Appeal**, shall have the opportunity to pursue his or her **Appeal** before a panel of **Physician**s and/or other health care professionals with appropriate expertise who have not been involved in the **Appeal** and who has no direct financial interest in the **Appeal** or outcome of the review. The **Member** and/or an authorized representative may attend the Level Two **Appeal** hearing, question the representatives of **HMO** and present his/her case and any additional information the **Member** wishes. Upon request, the **Member** and **HMO** shall provide each other with any additional information that will be presented at the review. The information must be provided to both parties at least five days prior to the review. If new information becomes available after that five day period, such information may be presented as soon as possible.

Within 10 business days of receipt of a Level Two **Appeal**, the **HMO** will acknowledge the **Appeal** in writing.

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

HMO Timeframe for Responding to an Adverse Benefit Determination **Appeal**

Type of Claim	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; for persons with a physical or mental disability, create an imminent and substantial limitation on their existing ability to live independently; or, the opinion of the **Physician** with knowledge of the **Member**'s medical condition, would subject the **Member** to severe pain that cannot be adequately managed without the requested care or treatment.	Within 72 hours Review provided by Medical Director (when clinical peer) or the Medical Director in consultation with clinical peer not involved in making the adverse benefit determination.	Within 36 hours Review provided by **HMO Appeal**s Committee.
Pre-Service Claim. A claim for a benefit that requires approval of the benefit in advance of obtaining medical care.	Within 30calendar days Medical Director (when clinical peer) or the Medical Director in consultation with clinical peer not involved in making the adverse benefit determination.	Within 15 calendar days Review provided by **HMO Appeal**s 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	Treated like an urgent care claim
Post-Service Claim. Any claim for a benefit that is not a pre-service claim.	Within 30 calendars days Medical Director (when clinical peer) or the Medical Director in consultation with clinical peer not involved in making the adverse benefit determination.	Within 30 business days Review provided by **HMO Appeal**s Committee.

AETNA HEALTH INC.
(COLORADO)

AUTISM BENEFITS
AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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) Atypical autism as a diagnosis with Pervasive Developmental Disorder--Not Otherwise Specified.

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

   Autism Spectrum Disorder Benefits. Covered Benefits include the services and supplies **Medically Necessary** for the diagnosis and treatment, (including behavioral therapy and Applied Behavioral Analysis), of **Autism Spectrum Disorder** when ordered by a **Physician** as part of a Treatment Plan and
   - The covered child is diagnosed with **Autism Spectrum Disorder**; and
   - The covered expenses are incurred prior to attainment of age 19.

   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.

   Treatment for **Autism Spectrum Disorders** shall include habilitative or rehabilitative care, including but not limited to:
   - Occupational therapy;
   - Physical therapy;
   - Speech therapy; or
   - Any combination of these therapies.

   Benefits for Occupational Therapy, Physical Therapy or Speech Therapy for **Autism Spectrum Disorders** are subject to the Habilitative/Rehabilitative Care maximum benefit amount, shown in the Schedule of Benefits.

   Coverage for Applied Behavioral Analysis for **Autism Spectrum Disorders** is subject to the maximum, shown in the Schedule of Benefits.

   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 Habilitative/Rehabilitative Care Maximum: 20 visits per each therapy. Coverage for Applied Behavioral Analysis is subject to a maximum benefit per year as follows:	Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.
Children up to age 9:	$34,000
Children from age 9 though age 18:	$12,000
Once the benefit maximums above have been reached, coverage for Applied Behavioral Analysis will cease.	

4. The **Covered Benefits** section of the **Certificate** is hereby amended. Items 3-6 under 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; except that coverage of Physical Therapy for congenital defects and birth abnormalities in **Covered Dependents** up to 6 years of age is without regard to whether the condition is acute or chronic. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.

c. Occupational Therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute illnesses and injuries; except that coverage of occupational therapy for congenital defects and birth abnormalities in **Covered Dependents** up to 6 years of age is without regard to whether the condition is acute or chronic. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.

d. Speech Therapy is covered for non-chronic conditions and acute illnesses and injuries; except that coverage of speech therapy for congenital defects and birth abnormalities in **Covered Dependents** up to 6 years of age is without regard to

whether the condition is acute or chronic. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.

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**.

AETNA HEALTH INC.
(COLORADO)

CERTIFICATE OF COVERAGE AMENDMENT

OUTPATIENT REHABILITATION
REHABILITATION THERAPIES FOR CONGENITAL DEFECTS
AND BIRTH ABNORMALITIES

Contract Holder Group Agreement Effective Date: January 1, 2013

The Rehabilitation Therapies For Congenital Defects and Birth Abnormalities benefits is hereby deleted from the Covered Benefits section of the **Certificate** and replaced with the following:

S. **Rehabilitation Therapies For Congenital Defects and Birth Abnormalities.**

- Up to a maximum of 20 therapy visits per **Contract Year** for physical therapy;
- Up to a maximum of 20 therapy visits per **Contract Year** for occupational therapy; and
- Up to a maximum of 20 therapy visits per **Contract Year** for speech therapy.

Therapy visits shall be distributed as **Medically Necessary** for **Member**s up to six (6) years of age without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.

AETNA HEALTH INC.
(COLORADO)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

1. The following is hereby added to the front page of your **Certificate**:

   IF A MEMBER HAS QUESTIONS REGARDING MEMBER SERVICES, PROBLEMS OR QUESTIONS OR QUESTIONS REGARDING COVERAGE UNDER THIS CERTIFICATE, THE MEMBER MAY CALL THE MEMBER SERVICES TOLL-FREE TELEPHONE NUMBER LISTED ON THE MEMBER'S IDENTIFICATION CARD OR DIRECT THEIR QUESTIONS TO THE FOLLOWING ADDRESS:

   AETNA HEALTH INC.
   6501 S. FIDDLER'S GREEN CIRCLE
   SUITE 310
   GREENWOOD VILLAGE, CO 80111

2. The following exclusion appearing in the Exclusions and Limitations section of the **Certificate** is hereby deleted:

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

   and replaced with the following:

   - Services which are not a **Covered Benefit** under this **Certificate**.

3. The following numbered item listed under the Conversion Privilege section of the **Certificate** is hereby deleted:

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

   and replaced with the following:

   3. Members who are covered by Medicare at the time their coverage under this Certificate is terminated are not eligible for conversion.

4. The Newborn Child and Adopted Child provision appearing under the Enrollment section of the Certificate is hereby deleted and replaced with the following:

   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 payment of a specific **Premium** is required to provide coverage for a covered child, the **Subscriber** must notify **HMO** of the birth of the newborn child and payment of

the required **Premium** must be furnished to **HMO** within 31 days after the date of birth in order to have the coverage continue beyond the 31 day period.

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. If payment of a specific **Premium** is required to provide coverage for a covered child, the **Subscriber** must notify **HMO** of the adoption and payment of the required **Premium** must be furnished to **HMO** within 31 days of the date the child is adopted or placed with the Subscriber for adoption.

5. The following is hereby added to the Dependent Eligibility section appearing in the Schedule of Benefits:

For an additional premium, if applicable, coverage is also available for an unmarried child who is under 25 years of age and is not a dependent as defined above if such child:

(1) has the same legal residence of the Subscriber or a covered spouse; or
(2) is financially dependent upon the Subscriber or a covered spouse.

The additional premium, if applicable shall be paid by you or the Contract Holder, at the discretion of the Contract Holder.

6. The following is hereby deleted from the Schedule of Benefits:

Member must demonstrate the Copayment amounts that have been paid during the year.

7. The Refusal of Treatment provision appearing in the General Provisions section of the **Certificate** is hereby deleted.

AETNA HEALTH INC.
(COLORADO)

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

Contract Holder Group Agreement Effective Date: January 1, 2013

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

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

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

   A **Member** may register a **Complaint** with **HMO**, as described in the Complaints and Appeals, External Review and Dispute Resolution sections of the **Certificate**, after receiving notice that **HMO** has or will terminate the **Member's** coverage as described in the Termination For Cause subsection of the **Certificate**. **HMO** will continue the **Member's** coverage in force until a final decision on the **Complaint** is rendered, provided the **Premium** is paid throughout the period prior to the issuance of that final decision. **HMO** may rescind coverage, to the date coverage would have terminated had the **Member** not registered a **Complaint** with **HMO**, if the final decision is in favor of **HMO**. If coverage is rescinded, **HMO** will provide the **Member** with a 30 day advance written notice prior to the date of the rescission, and refund any **Premiums** paid for any period after the termination date, minus the cost of **Covered Benefits** provided to 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 liability or responsibility under this **Certificate** for services provided on or after the date of termination of coverage, except as provided under the Continuation and Conversion section of this **Certificate**.

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

3. The Claims Procedure, Complaints and Appeals, **External Review** and Dispute Resolution section of the **Certificate**, and any amendments to these sections of the **Certificate** are replaced with the following:

CLAIM PROCEDURES

A claim occurs whenever a **Member** or the **Member's** authorized representative requests pre-authorization as required by the plan from **HMO**, a **Referral** as required by the plan from a **Participating Provider** or requests payment for services or treatment received. As an **HMO Member**, most claims do not require forms to be submitted. However, if a **Member** receives a bill for **Covered Benefits**, the bill must be submitted promptly to the **HMO** for payment. Send the itemized bill for payment with the **Member's** identification number clearly marked to the address shown on the **Member's** ID card.

HMO will make a decision on the **Member's** claim. Notice of the benefit determination on the claim will be provided to the **Member** within the below timeframes. Under certain circumstances, these time frames may be extended. If **HMO** makes an adverse benefit determination, notice will be provided in writing to the **Member**, or in the case of a concurrent care claim, to the **Participating Provider**. The notice will provide important information about making an **Appeal** of the adverse benefit determination. Please see the **Certificate** for more information about **Appeals**.

"**Adverse benefit determinations**" are decisions made by **HMO** that result in denial, reduction, or termination of a benefit or the amount paid for it. It also means a decision not to provide a benefit or service or termination of a **Member's** coverage back to the original effective date (rescission). Such adverse benefit determination may be based on:

- Your eligibility for coverage.
- Coverage determinations, including plan limitations or exclusions; except when the Member presents evidence from a medical professional that there is a reasonable medical basis that the exclusion does not apply to the denied benefit.
- The results of any Utilization Review activities.
- A decision that the service or supply is an **Experimental or Investigational Procedure**.
- A decision that the service or supply is not **Medically Necessary**.

A "**final adverse benefit determination**" is an **adverse benefit determination** that has been upheld by **HMO** at the exhaustion of the appeals process.

HMO Timeframe for Notification of a Benefit Determination

Type of Claim	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. The requirements apply to all written request received by **HMO** that are submitted by the **Member**, the **Member**'s designated representative or provider requesting a determination of coverage for a specific health care service or treatment for a specific **Member**	As soon as possible, but not later than 24 hours after the claim is made. If more information is needed to make an **Urgent Care Claim** decision, **HMO** will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide **HMO** with the additional information. **HMO** will notify the claimant within 48 hours of the earlier to occur: • the receipt of the additional information; or • the end of the 48 hour period given the **Physician** to provide **HMO** with the information.
Pre-Service Claim. A claim for a benefit that requires pre-authorization of the benefit in advance of obtaining medical care. The requirements apply to all written request received by **HMO** that are submitted by the **Member**, the **Member**'s designated representative or provider requesting a determination of coverage for a specific health care service or treatment for a specific **Member**.	Within 15 calendar days. **HMO** may determine that due to matters beyond its control an extension of this 15-calendar day claim decision period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if **HMO** notifies the **Member** within the first 15 calendar day period. If this extension is needed because **HMO** needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. The **Member** will have 45 calendar days, from the date

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

COMPLAINTS AND APPEALS

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

- **Inquiry.** An inquiry is any communication that has not been the subject of an adverse determination and that request redress or an action, omission or policy of the **HMO**.

- **Appeal.** An **Appeal** is a request to the **HMO** to reconsider a **Complaint** or an adverse benefit determination. The **Appeal** procedure for a **Complaint** or an **adverse benefit determination** has two levels.

- **Complaint.** A **Complaint** is any **Inquiry** that has not been explained or resolved to the **Member**'s satisfaction within three (3) business days of the **Inquiry** or any matter concerning an adverse determination.

- **Date of Receipt of a Notice.** The date that shall be calculated to be no less than 3 calendar days after the date the notice is postmarked by **HMO**.

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

A. **Complaints**.

If the **Member** is dissatisfied with the administrative services the **Member** receives from the **HMO** or wants to complain about a **Participating Provider,** call or write Member Services 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. **Peer-to-Peer Conversation**

For a pre-service claim determination, the **Participating Provider** rendering the service may request, orally or in writing on the **Member**'s behalf, a conversation between the **Participating Provider** and the **HMO** regarding the **HMO**'s adverse benefit determination. This conversation will take place within 5 calendar days of the **HMO**'s receipt of the request. If this conversation does not resolve the issue to the **Participating Provider**'s and **Member**'s satisfaction, the adverse benefit determination may be appealed as stated in Section D below.

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

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

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

D. **Appeals of Adverse Benefit Determinations.**

The **Member** will receive written notice of an adverse benefit determination from the **HMO**. The notice will include the reason for the decision and it will explain what steps must be taken if the **Member** wishes to **Appeal.** The notice will also identify the **Member's** rights to receive additional information that may be relevant to an **Appeal**. Requests for an **Appeal** must be made in writing within 180 calendar days from the date of the notice, or after the notification of a benefit denied due to a contractual exclusion except a request for a Level One Appeal of an urgent care claim may also be oral. If the deadline for filing a request ends on a weekend or holiday, the deadline will be extended to the next business day.

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**.

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

The **HMO** provides for two level(s) of **Appeal** of the **adverse benefit determination**. The First Level **Appeal** shall be evaluated by a **Physician** who shall consult with an appropriate clinical peer or peers, unless the reviewing **Physician** is a clinical peer. The **Physician** and clinical peers shall not have been involved in the initial adverse benefit determination. A person who was previously involved with the denial may answer questions. All written denials of requests for **Covered Benefit**s on the ground that such benefits are not **Medically Necessary**, appropriate, effective, or efficient shall be signed by a licensed **Physician** familiar with standards of care in Colorado.

If the **HMO** upholds an adverse benefit determination at the first level of appeal, and the reason for the adverse determination was based on **Medical Necessity**, or **Experimental or Investigational** reasons, or a contractual exclusion and the **Member** presents evidence for a medical professional that there is a reasonable medical basis that the exclusion does not apply to the denied benefit, the **Membe**r or his/her authorized representative have the right to pursue an **Appeal** to an independent utilization review organization (IURO), or file the voluntary Level Two **Appeal**.

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 at the conclusion of the Level One **Appeal** explaining the **Member's** right to make a Level Two **Appeal**. If the deadline for filing a request ends on a weekend or holiday, the deadline will be extended to the next business day. Any **Member** or **Provider** acting on behalf of a **Member** with the **Member's** consent, who is dissatisfied with the results of a Level One **Appeal**, shall have the opportunity to pursue their **Appeal** before a panel of **Physicians** and/or other health care professionals with appropriate expertise who have not been involved in the **Appeal** and who has no direct financial interest in the **Appeal** or outcome of the review. The **Member** and/or an authorized representative may attend the Level Two **Appeal** hearing, question the representatives of the **HMO** and present their case and any additional information the **Member** wishes. Upon request, the **Member** and the **HMO** shall provide each other with any additional information that will be presented at the review. The information must be provided to both parties at least 5 days prior to the review. If new information becomes available after that 5 day period, such information may be presented as soon as possible.

Within 10 business days of receipt of a Level Two **Appeal**, the **HMO** will acknowledge the **Appeal** in writing.

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

HMO Timeframe for Responding to an Adverse Benefit Determination Appeal

Type of Claim	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	Within 24 hours	Within 36 hours

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; for persons with a physical or mental disability, create an imminent and substantial limitation on their existing ability to live independently; or, the opinion of the **Physician** with knowledge of the **Member**'s medical condition would subject the **Member** to severe pain that cannot be adequately managed without the requested care or treatment.	Review provided by Medical Director (when clinical peer) or the Medical Director in consultation with clinical peer not involved in making the adverse benefit determination.	Review provided by **HMO** Appeals Committee. Review provided by **HMO** personnel not involved in making the **adverse benefit determination** or Level One **Appeal** decision.
Pre-Service Claim. A claim for a benefit that requires approval of the benefit in advance of obtaining medical care.	Within 15 calendar days Review provided by Medical Director (when clinical peer) or the Medical Director in consultation with clinical peer not involved in making the adverse benefit determination.	Within 15 calendar days Review provided by **HMO** Appeals Committee. Review provided by **HMO** personnel not involved in making the **adverse benefit determination** or Level One **Appeal** decision.
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.	Treated like an urgent care claim.
Post-Service Claim. Any claim for a benefit that is not a pre-service claim.	Within 30 calendar days Review provided by Medical Director (when clinical peer) or the Medical Director in consultation with clinical peer not involved in making the adverse benefit determination	Within 30 calendar days Review provided by **HMO** Appeals Committee. Review provided by **HMO** personnel not involved in making the **adverse benefit determination** or Level One **Appeal** decision.

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

HMO's failure to comply with the internal **Appeal** process described above will deem the internal review process exhausted and permit a **Member** to request and independent **External Review**.

E. **Record Retention.**

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

F. **Fees and Costs.**

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

INDEPENDENT EXTERNAL REVIEW OF BENEFIT DENIAL

Following the **Appeals** processes described above, independent external review of benefit denials is available under this **Certificate** either following receipt of the first or second level **Appeal** letters. The **Member** will be notified in writing of their right to request an external review and of the procedure for making such a request should the First or Second Level **Appeal** review result in a determination that benefits are not payable under this **Certificate**.

A **Member** is only eligible to request an External Review for the following:

- medical services or treatment which have been denied either because they were not **Medically Necessary**, were medically inappropriate; or
- because the proposed service or treatment is considered **Experimental or Investigational**; or
- for an excluded benefit for which the claimant is able to present evidence from a medical professional that there is reasonable medical basis that the contractual exclusion does not apply to the covered benefit.

There is no minimum dollar amount for a claim to be eligible for an **External Review**.

A. **Request for External Review.**

1. Within 4 months after the **Date of Receipt of a Notice** of the **HMO's adverse benefit determination** following the completion or exhaustion of the First Level **Appeal** or within 60 calendar days after the completion of a voluntary Second Level **Appeal**, a **Member** or the **Member**'s designated representative may file a request for an **External Review** with the **HMO**.

2. All requests for **External Review** shall be made in writing to the **HMO** and must include a completed **External Review** request form as specified by the Division of Insurance. A copy of such form will be provided by the **HMO** following denial of Second Level **Appeal**.

3. A **Member** or **Member**'s designated representative requesting an expedited **External Review** must include a request for an expedited review in the written request described below.

4. All requests for **External Review** shall include a signed consent, authorizing the **HMO** to disclose protected health information, including medical records, concerning the **Member** that is pertinent to the **External Review**.

5. A request for **External Review** submitted by the **Member** or the **Member**'s designated representative may include new information, if significantly different from information

provided or considered during the internal review process, for consideration by the **HMO** and the independent **External Review** entity.

6. **HMO**'s denial of a request for a standard **External Review** shall be made in writing and include the specific reasons for the denial and provide information about appealing the denial of the request with the Division of Insurance. A copy of the denial shall be sent to the Division of Insurance at the same time it is sent to the **Member** or, if applicable the **Member**'s designated representative.

7. **HMO**'s denial of a request for an expedited **External Review** shall be made in writing and transmitted electronically or by facsimile or any other available expeditious method. If will include the specific reasons for the denial and shall provide information about appealing the denial of the request with the Division of Insurance. A copy of the denial shall be sent to the Division of Insurance at the same time it is sent to the **Member** or, if applicable the **Member**'s designated representative.

B. **Standard External Review.**

1. Except as provided in Paragraph (2) of this Subsection B, the **HMO**, upon receipt of a complete request for an **External Review** pursuant to the process under Request for **External Review** above, shall deliver a copy of the request to the Commissioner of Insurance ("commissioner") within 2 working days.

2. If the **HMO**, before the expiration of the deadline for sending notification to the commissioner, reverses its final **Adverse Determination** based on new information submitted by the **Member** or the **Member's** designated representative pursuant to the process under Request for **External Review** above, the **HMO** must notify the **Member** or the **Member's** designated representative within one working day of its reversal, electronically, by facsimile, or by telephone, followed by a written confirmation.

3. Within 2 working days from the time a request for **External Review** is received from the **HMO**, the commissioner shall assign an independent **External Review** entity to conduct the **External Review** that has been approved pursuant to Colorado regulation. The commissioner shall randomly select an independent **External Review** entity that does not have a conflict of interest. Upon assignment, the commissioner shall notify the **HMO**, electronically, by facsimile, or by telephone, followed by a written confirmation, of the name and address of the independent **External Review** entity to which the **Appeal** should be sent.

4. After receipt of notice from the commissioner, the **HMO** shall notify within 1 working days the **Member** or the **Member's** designated representative, electronically, by facsimile, or by telephone, followed by a written confirmation. The notice shall include a written description of the independent **External Review** entity that the commissioner has selected to conduct the **External Review** and information regarding how the **Member** or the **Member's** designated representative may provide the commissioner with documentation regarding any potential conflict of interest of the independent **External Review** entity as described in Colorado regulation.

5. Within 2 working days of receipt of notice from **HMO**, the **Member** or the **Member's** designated representative may provide the commissioner with documentation regarding a potential conflict of interest of the independent **External Review** entity, electronically, by facsimile, or by telephone, followed by a written confirmation. If the commissioner determines that the independent **External Review** entity presents a conflict of interest as described in §10-16-113.5(4)(b), C.R.S., the commissioner shall assign, within 1 working day, another independent **External Review** entity to conduct the **External Review**. Upon this reassignment, the commissioner shall notify the **HMO**, electronically, by

facsimile, or by telephone, followed by a written confirmation, of the name and address of the new independent **External Review** entity to which the **Appeal** should be sent. The commissioner will notify the **Member** or the **Member's** designated representative in writing of the commissioner's determination regarding the potential conflict of interest and the name and address of the new independent **External Review** entity, if applicable.

6. Within 5 working days of receipt of the notice from **HMO**, the **Member** or the **Member**'s designated representative may provide additional information to the independent **External Review** entity that shall be considered during the review. The independent **External Review** organization is not required to, but may, accept and consider additional information submitted after 5 working days. The independent **External Review** organization shall forward this information to **HMO** within 1 working day of receipt.

   In reaching a decision, the independent **External Review** entity is not bound by any decisions or conclusions reached during the **HMO's** utilization review process or the **HMO's** internal **Appeal** process.

7. Within 5 working days from the date the **HMO** receives notice from the commissioner, the **HMO** shall deliver to the assigned independent **External Review** entity the following documents and information considered in making the **HMO's** final Adverse Determination including:
   a. any and all information submitted to the **HMO** by a health care professional or the **Member** or **Member's** designated representative in support of the request for coverage under the **Certificate;**

   b. any and all information used by the **HMO** during the internal **Appeal** process to determine the **Medical Necessity**, medical appropriateness, medical effectiveness, or medical efficiency of the proposed treatment or service, including medical and scientific evidence and clinical review criteria;

   c. a copy of any and all denial letters issued by the **HMO** concerning the case under review;

   d. a copy of the signed consent form, authorizing the **HMO** to disclose protected health information, including medical records, concerning the **Member** that is pertinent to the **External Review**; and

   e. an index of all submitted documents.

8. Within 2 working days of receipt of the material specified in Subsection B.7 above, the independent **External Review** entity shall deliver to the **Member** or the **Member's** designated representative the index of all materials that the **HMO** has submitted to the independent **External Review** entity. **HMO** shall provide to the **Member** or **Member's** designated representative, upon request, all relevant information supplied to the independent **External Review** entity that is not confidential or privileged under state or federal law concerning the case under review.
   a. The independent **External Review** entity shall notify the **Member** or the **Member's** designated representative, the healthcare professional of the **Member**, and the **HMO** of any additional medical information required to conduct the review after receipt of the documentation required pursuant to Subsection B.7. Within 5 working days of such a request, the **Member** or the **Member's** designated representative or the health care professional of the **Member** shall submit the additional information, or an explanation of why the additional information is not being submitted to the certified independent **External Review** entity and the **HMO**.

b. If the **Member** or **Member's** designated representative or the health care professional of the **Member** fails to provide the additional information or the explanation of why additional information is not being submitted within the timeframe specified the independent **External Review** entity shall make a decision based on the information submitted by the **HMO**.

9. If the **HMO** fails to provide the required documents and information within the time specified, the independent **External Review** entity may terminate the **External Review** and make a decision to reverse the **HMO's** final adverse determination.

Immediately upon the reversal the independent **External Review** entity shall notify the **Member**, if applicable, the **Member**'s designated representative, the **HMO**, and the commissioner.

10. Except as provided in Subsection B.9 failure by the **HMO** to provide the documents and information within the time specified shall not delay the conduct of the **External Review**.

12. Upon receipt of the information permitted to be forwarded pursuant to the section on Request for **External Review** above, **HMO** may reconsider the **HMO's** final adverse determination that is the subject of the **External Review**. Consideration of new information by the **HMO**, of the **HMO's** final adverse determination, shall not delay or terminate the **External Review**. The **External Review** may only be terminated if the **HMO** decides to reverse the **HMO's** final adverse determination and provide coverage or payment for the health care service that is the subject of **HMO's** final adverse determination.

a. Within 1 working day of making the decision to reverse the **HMO's** final adverse determination, the **HMO** shall notify the **Member** or the **Member**'s designated representative, the independent **External Review** entity, and the commissioner of its decision, electronically, by facsimile, or by telephone followed by a written confirmation.

b. The independent **External Review** entity shall terminate the **External Review** upon receipt of the notice from the **HMO**.

13. In addition to the documents and information provided to the independent **External Review** entity, the assigned independent **External Review** entity, to the extent the documents or information are available, shall review the following:

- The **Member**'s medical records.
- The attending health care professional**'s** recommendation.
- Consulting reports from appropriate health care professional**s** and other documents submitted by the **HMO**, **Member**, the **Member**'s authorized representative, or the **Member**'s treating provider.
- Any applicable clinical review criteria developed and used by the **HMO**.
- Medical and scientific evidence determined to be relevant and appropriate by the independent review entity.

The independent **External Review** entity shall base its determination on an objective review of relevant medical and scientific evidence.

14. Within 45 days after the date of receipt of the request for **External Review** by the independent **External Review** entity it shall:

- Make a decision to uphold of reverse the **HMO**'s **adverse benefit determination**; and

- Provide a written notification of its decision to the following:
  - The **Member**;
  - If applicable, the **Member**'s designated representative;
  - **HMO**;
  - The **Physician** or other health care profession of the **Member**; and
  - The Commissioner.

In addition to the requirements of Colorado statute, the independent **External Review** entity shall include in the notice

i. The date the independent **External Review** entity received the assignment from the commissioner to conduct the **External Review**;

ii. The date of its decision; and

iii. An explanation that the **External Review** decision is the final **Appeal** available to the consumer under state insurance law.

Upon **HMO's** receipt of the independent **External Review** entity's notice of a decision reversing **HMO's** final adverse determination, **HMO** shall approve the coverage that was the subject of **HMO's** final adverse determination. For concurrent and prospective reviews, **HMO** shall approve the coverage within 1 working day. For retrospective reviews, the **HMO** shall approve the coverage within 5 working days. **HMO** shall provide written notice of the approval to the **Member** or the **Member's** designated representative within 1 working day of the **HMO's** approval of coverage. The coverage shall be provided subject to the terms and conditions applicable to benefits under the **Certificate.**

C. **Expedited External Review.**

1. Except as provided in Section C.11 of this Expedited **External Review** section, a **Member** or the **Member**'s designated representative may make a request for an expedited **External Review** with the **HMO** if the **Member** has a medical condition where the timeframe for completion of a standard **External Review** would seriously jeopardize the life or health of the **Member**, would jeopardize the **Member**'s ability to regain maximum function or, for persons with a disability, create an imminent and substantial limitation of their existing ability to live independently.

2. The **Member**'s or the **Member's** designated representative's request for an expedited review must include a **Physician**'s certification that the **Member**'s medical condition meets the criteria in Section C.1 above.

3. Upon receipt of a request for an expedited **External Review**, the **HMO** shall notify and send a copy of the request to the commissioner within 1 working day electronically or by telephone or facsimile or any other available expeditious method.

4. Within 1 working day of the time the commissioner receives a request for an expedited **External Review**, the commissioner shall randomly assign an independent **External Review** entity that has been approved pursuant to Colorado regulation to conduct the review and to make a decision regarding the **HMO's** final adverse determination. The commissioner shall select an independent **External Review** entity that does not have a conflict of interest with the case, as described in Colorado regulation. Upon assignment,

the commissioner shall inform the **HMO** of the name and address of the independent **External Review** entity to which the **Appeal** should be sent.

5. Within 1 working day of notice from the commissioner, the **HMO** shall notify the **Member** or **Member's** designated representative, electronically, by facsimile, or by telephone followed by a written confirmation. The notice shall include a written description of the independent **External Review** entity that the commissioner has selected to conduct the independent review.

   In reaching a decision, the independent **External Review** entity is not bound by any decisions or conclusions reached during the **HMO's** utilization review process or the **HMO's** internal **Appeal** process as set forth in Colorado insurance regulation.

6. Immediately upon receipt of the notification, **HMO** shall provide or transmit all necessary documents and information, as described in Standard **External Review** above, considered in making the **HMO's** final adverse determination to the independent **External Review** entity electronically or by telephone or facsimile or any other available expeditious method.

7. In addition to the documents and information provided or transmitted to the assigned independent **External Review** entity, the independent **External Review** entity, to the extent the information or documents are available, shall consider the following in reaching a decision:
   - The **Member**'s medical records.
   - The attending health care professional's recommendation.
   - Consulting reports from appropriate health care professionals and other documents submitted by the **HMO**, **Member**, the **Member**'s authorized representative, or the **Member**'s treating provider.
   - Any applicable clinical review criteria developed and used by the **HMO**.
   - Documents and information regarding medical and scientific evidence, to the extent the independent review entity considers them appropriate.

   The independent **External Review** entity shall base its determination on an objective review of relevant medical and scientific evidence.

8. Except as provided below in Section C.19, within 72 hours after the date of receipt of the assignment of the request for **External Review**, the independent **External Review** entity shall:
   a. Make a decision to uphold or reverse the **HMO's** final adverse determination; and

   b. Provide a notification to the following:
      - The **Member**
      - The **Member**'s designated representative, if applicable;
      - **HMO**
      - The **Member**'s physician; and
      - The Commissioner.

9. If the notice provided was not in writing, within 48 working days after the date of providing that notice, the independent **External Review** entity shall:
   a. Provide written confirmation of the decision to the **Member**, if applicable, the **Member**'s designated representative, the **HMO**, and the commissioner; and

b. Include the information set forth in section B.13.C of Standard **External Review** above.

10. **HMO's** responsibility when the adverse benefit determination is reversed by the independent **External Review** entity:
    - Immediately upon **HMO's** receipt of the independent **External Review** entity's notice of a decision reversing the **HMO's** final adverse determination, the **HMO** shall approve the coverage that was the subject of the **HMO's** final adverse determination. **HMO** shall provide written notice of the approval to the **Member** or the **Member's** designated representative. The coverage shall be provided subject to the terms and conditions applicable to benefits under the **Certificate**.

11. An expedited **External Review** may not be provided for retrospective **adverse benefit determinations**.

A **Member** may request a concurrent expedited **External Review** when a request for an expedited internal review has been made.

D. **Binding Nature of External Review Decision.**

1. An **External Review** decision is binding on the **HMO** and the **Member** except to the extent **HMO** and **Member** have other remedies available under federal or state law; however, the determination of the expert reviewer will create a rebuttable presumption in any subsequent action.

2. A **Member** or the **Member**'s designated representative may not file a subsequent request for **External Review** involving **HMO's** final **adverse benefit determination** for which the **Member** has already received an **External Review** decision.

AETNA HEALTH INC.
(COLORADO)

CERTIFICATE OF COVERAGE AND
SCHEDULE OF BENEFITS
AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

- If a **Member's** coverage under the **Certificate** is rescinded, **HMO** will provide the **Member** with a 30-day advance written notice prior to the date of the rescission.

AETNA HEALTH INC.
(COLORADO)

AMENDMENT TO THE CERTIFICATE OF COVERAGE

CONTRACEPTIVES AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

The Contraceptives provision appearing under the Covered Benefits section of your **Certificate** is hereby deleted and replaced with the following:

Contraceptives

Covered Benefits for contraception are provided in the same manner as any other sickness, injury, disease or condition as otherwise covered under this **Certificate** for the following:

- Prescription contraceptive drugs. This includes medically acceptable drugs, devices or procedures used to prevent pregnancy;
- Voluntary sterilization procedures;
- Hormone injections for contraception;
- Emergency contraception. An emergency contraception is a drug approved by the Federal Food and Drug Administration that prevents pregnancy after sexual intercourse, including but not limited to, oral contraceptive pills. Emergency contraception does not include RU-486, mifepristone or any other drug or device that induces a medical abortion;
- Intrauterine devices (IUDs), subdermal implants and the insertion, management and removal of such devices.

Over-the-counter contraceptive drugs or devices for which a prescription is not required and which are not otherwise covered under this **Certificate** are not covered.

AETNA HEALTH INC.
6501 S. FIDDLER'S GREEN CIRCLE
SUITE 310
GREENWOOD VILLAGE, CO 80111

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;
- significant change in health coverage of employee or spouse attributable to spouse's employment.

AETNA HEALTH INC.
(COLORADO)

AETNA OPEN ACCESS RIDER

Contract Holder Group Agreement Effective Date: January 1, 2013

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

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

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

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

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

The **PCP** provides services for the treatment of routine illnesses, injuries, well baby and preventive care services which do not require the services of a **Specialist**, and for 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** will be subject to the **PCP Copayment** listed on the Schedule of Benefits when a **Member** obtains **Covered Benefits** from any **Participating PCP**.

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 under this **Certificate** 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 **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.

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.
(COLORADO)

6501 S. FIDDLER'S GREEN CIRCLE
SUITE 310
GREENWOOD VILLAGE, CO 80111

DOMESTIC PARTNER RIDER

Contract Holder Group Agreement Effective Date: 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;
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

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(COLORADO)

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.

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

The 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.

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(COLORADO)

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 2-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 the applicable cost sharing.

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, weight reduction or treat obesity, including **Morbid Obesity.**

Except as provided by this rider, this exclusion applies even when comorbid conditions exists.

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.
(COLORADO)

PRESCRIPTION PLAN RIDER

Group Agreement Effective Date: January 1, 2013

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

DEFINITIONS

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

- **Brand Name Prescription Drug(s).** Prescription drugs and insulin with a proprietary name assigned to it by the manufacturer or distributor and so indicated by MediSpan or any other similar publication designated by **HMO** or an affiliate. **Brand Name Prescription Drugs** do not include those drugs classified as **Generic Prescription Drugs** as defined below.

- **Contracted Rate.** The negotiated rate between **HMO** or an affiliate and the **Participating Retail** or **Mail Order Pharmacy**. This rate does not reflect or include any amount **HMO** or an affiliate may receive under a rebate arrangement between **HMO** or an affiliate and a drug manufacturer for any drugs, including any drugs on the **Drug Formulary**.

- **Drug Formulary**. A list of prescription drugs and insulin established by **HMO** or an affiliate, which includes both **Brand Name Prescription Drugs,** and **Generic Prescription Drugs**. This list is subject to periodic review and modification by **HMO** or an affiliate. A copy of the **Drug Formulary** will be available upon request by the **Member** or may be accessed at the pharmacy website, at www.aetna.com.

- **Drug Formulary Exclusions List**. A list of prescription drugs excluded from the **Drug Formulary**, subject to change from time to time at the sole discretion of **HMO**.

- **Generic Prescription Drug(s)**. Prescription drugs and insulin, whether identified by their chemical, proprietary, or non-proprietary name, that are accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by MediSpan or any other similar publication designated by **HMO** or an affiliate.

- **Non-Formulary Prescription Drug(s).** A product or drug not listed on the **Drug Formulary** which includes drugs listed on the **Drug Formulary Exclusions List**.

- **Participating Mail Order Pharmacy.** A pharmacy, which has contracted with **HMO** or an affiliate to provide covered outpatient prescription drugs or medicines, and insulin to **Members** by mail or other carrier.

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

- **Precertification Program.** For certain outpatient prescription drugs, prescribing **Physicians** must contact **HMO** or an affiliate to request and obtain coverage for such drugs. The list of drugs requiring precertification is subject to change by **HMO** or an affiliate. An updated copy of the list of drugs requiring precertification shall be available upon request by the **Member** or may be accessed at the pharmacy website, at www.aetna.com.

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

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

COVERED BENEFITS

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

A. **Outpatient Prescription Drug Open Formulary Benefit**

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

B. Each prescription is limited to a maximum 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 for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information), or the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer reviewed journal. Coverage of off label use of these drugs may, in **HMO's** sole discretion, be subject to the **Precertification Program** , the **Step Therapy Program,** or other **HMO** requirements or limitations.

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

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

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

When a **Member** obtains an emergency or **Urgent Care** prescription at any **Participating Retail Pharmacy,** including an out-of-area **Participating Retail Pharmacy**, **Member** will pay to the **Participating Retail Pharmacy** the **Copayment(s),** plus the **Brand Name Prescription Drug** cost differentials where applicable and as described below. **Members** are required to present their ID card at the time the prescription is filled. **HMO** will not cover claims submitted as a direct reimbursement request from a **Member** for a prescription purchased at a **Participating Retail Pharmacy** except upon professional review and approval by **HMO** in its sole discretion. **Members** must access a **Participating Retail Pharmacy** for **Urgent Care** prescriptions inside the **HMO Service Area**.

E. **Mail Order Prescription Drugs.** Subject to the terms and limitations set forth in this rider, **Medically Necessary** outpatient Prescription drugs are covered when dispensed by the **Participating Mail Order Pharmacy** designated by **HMO** and when prescribed by a **Provider** licensed to prescribe federal legend prescription drugs. **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.**

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

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

- **Contraceptives.**

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

  1. Oral Contraceptives.
  2. Diaphragms, 1 per 365 consecutive day period**.**
  3. Injectable contraceptives, the prescription plan **Copayment** applies for each vial up to a maximum of 5 vials per calendar year.
  4. Contraceptive patches
  5. Contraceptive rings
  6. Norplant and IUDs are covered when obtained from a **Participating Physician.** The **Participating Physician** will provide insertion and removal of the device. An office visit **Copayment** will apply, if any. A **Copayment** for the contraceptive device may also apply.

G. **Copayments:**

Member is responsible for the **Copayments** specified in this rider. The **Copayment,** if any, is payable directly to the **Participating Retail** or **Mail Order Pharmacy** for each prescription 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 Mail Order Pharmacy**, not to exceed a 90 day supply, 2 **Copayments**

are payable for each supply dispensed**.** The **Copayment** does not apply to the Maximum Out-of-Pocket Limit shown in the Schedule of Benefits for the medical plan, if any.

Prescription Drug/Medicine Quantity	**Generic Formulary Prescription Drugs**	**Brand Name Formulary Prescription Drugs**	**Non-Formulary Prescription Drugs**
Less than a 31 day supply	**$20**	**$40**	**$70**

EXCLUSIONS AND LIMITATIONS

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

A. **Exclusions**.

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

1. Any drug which does not, by federal or state law, require a prescription order (i.e., an over-the-counter (OTC) drug) or for which an equivalent over-the-counter product in strength, is available even when a prescription is written, unless otherwise covered by **HMO**.
2. Any drug determined not to be **Medically Necessary** for the treatment of disease or injury unless otherwise covered under this rider.
3. Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by **HMO**.
4. Cosmetic or any drugs used for cosmetic purposes or to promote hair growth, including but not limited to health and beauty aids.
5. Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps.
6. Needles and syringes, including but not limited to diabetic needles and syringes.
7. Any medication which is consumed or administered at the place where it is dispensed, or while a **Member** is in a **Hospital**, or similar facility; or take home prescriptions dispensed from a **Hospital** pharmacy upon discharge, unless the pharmacy is a **Participating Retail Pharmacy**.
8. Immunization or immunological agents, including but not limited to, biological sera, blood, blood plasma or other blood products administered on an outpatient basis, allergy sera and testing materials.
9. Drugs used for the purpose of weight reduction (e.g., appetite suppressants), including the treatment of obesity.
10. Any refill in excess of the amount specified by the prescription order. Before recognizing charges, **HMO** may require a new prescription or evidence as to need, if a prescription or refill appears excessive under accepted medical practice standards.
11. Any refill dispensed more than 1 year from the date the latest prescription order was written, or as otherwise permitted by applicable law of the jurisdiction in which the drug is dispensed.
12. Drugs prescribed for uses other than uses approved by the Food and Drug Administration (FDA) under the Federal Food, Drug and Cosmetic Law and regulations, or any drug labeled "Caution: Limited by Federal Law to Investigational Use", or experimental drugs except as otherwise covered under this rider.
13. Medical supplies, devices and equipment and non-medical supplies or substances regardless of their intended use.
14. Test agents and devices, including but not limited to diabetic test agents.
15. Injectable drugs used for the purpose of treating **Infertility**, unless otherwise covered by **HMO**.
16. Injectable drugs, except for insulin.
17. Oral and implantable contraceptives and contraceptive devices, unless otherwise covered under this rider.
18. Prescription orders filled prior to the effective date or after the termination date of the coverage provided by this rider.
19. Replacement for lost or stolen prescriptions.

20. Performance, athletic performance or lifestyle enhancement drugs and supplies.
21. 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.
22. 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.
23. Medication packaged in unit dose form. (Except those products approved for payment by **HMO)**.
24. Prophylactic drugs for travel.
25. Drugs recently approved by the FDA, but which have not yet been reviewed by the Aetna Health Inc. Pharmacy Management Department and Therapeutics Committee.
26. Drugs for the convenience of **Members** or for preventive purposes.
27. 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.
28. Sildenafil citrate, phentolamine, apomorphine and alprostadil in oral, injectable and topical (including but not limited to gels, creams, ointments and patches) forms or any other form used internally or externally. Any prescription drug in oral, topical or any other form that is in a similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes unless otherwise covered under this rider.
29. Nutritional supplements.
30. Smoking cessation aids or drugs.
31. Growth hormones.
32. 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(s) of the **Certificate**.

3. **HMO** is not responsible for the cost of any prescription drug for which the actual charge to the **Member** is less than the required **Copayment** or payment which applies to the **Prescription Drug Deductible Amount**, if any, or for any drug for which no charge is made to the recipient.

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

5. 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.
(COLORADO)

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.
6501 SOUTH FIDDLER'S GREEN CIRCLE MAIL STOP F807, SUITE 310
GREENWOOD VILLAGE, CO 80111

(COLORADO)

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: 749
Contract Holder Service Areas: CO01

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. The family Maximum Out-of-Pocket Limit can be met by a combination of family members with no single individual within the family contributing more than the individual limit.	
Maximum Benefit	**Unlimited per Member per lifetime**

OUTPATIENT BENEFITS

Benefit	Copayment
Primary Care Physician Services	
Adult Physical Examination including Immunizations	**$0 per visit**
Visits are subject to the following visit maximum:	
Adults 18-65 years old: 1 visit per 12-month period	
Adults over 65 years old: 1 visit per 12-month period	
Well Child Physical Examination including Immunizations and Child Health Supervision Services	**$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 visits for congenital and birth abnormalities for a Covered Dependent under age 5 to be provided throughout the calendar year**	**$20 per visit**
Outpatient Facility Visits	**$20 per visit**
Diagnostic X-Ray Testing	**$0 per visit**
Complex Imaging Services, including, but not limited to: Magnetic Resonance Imaging (MRI); Computerized Axial Tomography (CAT); and Positron Emission Tomography (PET)	**$0 per visit**
Breast Cancer Screening with Mammography	**$0 per visit**
Minimum Benefit	**The lesser of $105.50 per mammography screening or the actual charge for such screening**
Diagnostic Laboratory Testing	**$0 per visit**
Outpatient Emergency Services **Hospital Emergency Room or Outpatient Department**	**$50 per visit**
Urgent Care Facility	**$25 per visit**
Ambulance	**$0 per trip**
Outpatient Mental 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 **Limited to 3 intermittent visit(s) per day provided by a Participating home health care agency; 1 visit equals a period of 4 hours or less.**	
Unlimited visits per calendar year	**$0 per visit**
Outpatient Hospice Care Visits	**$0 per visit**
Injectable Medications	**$10 per visit or per prescription or refill**

INPATIENT BENEFITS

Benefit	**Copayment**
Acute Care	**$100 per admission**
Mental 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 60 days per calendar year**	**$100 per admission (waived if a Member is transferred from a Hospital to a Skilled Nursing Facility)**
Hospice Care	**$0 per admission (waived if a Member is transferred from a Hospital to a Hospice Care facility)**
Transplant	
Transplant Facility Expense Services	
Inpatient Care	**$100 per admission**

ADDITIONAL BENEFITS

Benefit	**Copayment**
Eye Examination by a Specialist (including refraction) as per the schedule in the Certificate	**$20 per visit**
Subluxation **20 visits per calendar year**	**$20 per visit**

Durable Medical Equipment (DME)	**50% (of the cost) per item**
DME Maximum Benefit	**Unlimited per Member per calendar year**
Cervical Cancer Immunization One Immunization per lifetime only for females up to the age limitation recommended by, and for whom a vaccination is recommended by, the Advisory Committee on Immunization Practices of the United States Department of Health and Human Services	**$0 per visit**
Early Intervention Services **Maximum per calendar year**	**$6,361**

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.

For an additional premium, if applicable, coverage is also available for an unmarried child who is under 25 years of age and is not a dependent as defined above if such child:

1. **has the same legal residence of the Subscriber or a covered spouse; or**
2. **is financially dependent upon the Subscriber or a covered spouse.**

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.