AETNA HEALTH INC.
(MASSACHUSETTS)

MINIMUM CREDITABLE COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The face page of the **Group Agreement** is hereby amended to add the following:

AETNA HEALTH INC.
(MASSACHUSETTS)

GROUP AGREEMENT COVER SHEET

Contract Holder:	**The Government of the District of Columbia**
Contract Holder Number:	172614 760
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 Massachusetts

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: 760
Contract Holder Group Agreement Effective Date: January 1, 2013

AETNA HEALTH INC.
(MASSACHUSETTS)

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 1 ½% 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 31 day grace period (the "**Grace Period"),** this **Group Agreement** will be automatically terminated pursuant to Section 6.3 hereof.

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

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

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

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

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

3.5 **Changes in Premium.** **We** may also adjust the **Premium** rates and/or the manner of calculating **Premiums** effective as of 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 its agent or broker of intent to terminate.

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

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

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

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

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

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

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

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

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

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

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

SECTION 7. PRIVACY OF INFORMATION

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

7.2 **Disclosure of Protected Health Information**. **We** will not provide protected health information ("PHI"), as defined in HIPAA, to **Contract Holder**, and **Contract Holder** will not request PHI from **Us**, unless **Contract Holder** has either:

- provided the certification required by 45 C.F.R. § 164.504(f) and amended **Contract Holder's** plan documents to incorporate the necessary changes required by such rule; or
- provided confirmation that the PHI will not be disclosed to the "plan sponsor", as such term is defined in 45 C.F.R. § 164.501.

7.3 **Brokers and Consultants**. To the extent any broker or consultant receives PHI in the underwriting process or while advocating on behalf of a **Member**, **Contract Holder** understands and agrees that such broker or consultant is acting on behalf of **Contract Holder** and not **Us**. We are entitled to rely on **Contract Holder's** representations that any such broker or consultant is authorized to act on **Contract Holder's** behalf and entitled to have access to the PHI under the relevant circumstances.

SECTION 8. INDEPENDENT CONTRACTOR RELATIONSHIPS

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

Participating Providers are solely responsible for any health services rendered to their **Member** patients. **We** make no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any **Physician**, **Hospital** or other **Participating Provider**. A **Provider's** participation may be terminated at any time without advance notice to the **Contract Holder** or **Members**, subject to applicable law. **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.
(MASSACHUSETTS)

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.
(MASSACHUSETTS)

AMENDMENT TO THE GROUP AGREEMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

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

AETNA HEALTH INC.
(MASSACHUSETTS)

MINIMUM CREDITABLE COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The face page of the **Certificate** is hereby amended to add the following:

This health plan **meets Minimum Creditable Coverage standards** and **will satisfy** the individual mandate that you have health insurance.
Please see below for additional information.

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This health plan **meets Minimum Creditable Coverage standards** that are effective January 1, 2010 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you **will satisfy** the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2010. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

AETNA HEALTH INC.
MASSACHUSETTS

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 Massachusetts.

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

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

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

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

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

INTERPRETER AND TRANSLATION SERVICES. YOU MAY CONTACT MEMBER SERVICES AT THE TOLL-FREE TELEPHONE NUMBER LISTED ON YOUR I.D. CARD TO RECEIVE INFORMATION ON INTERPRETER AND TRANSLATION SERVICES RELATED TO ADMINISTRATIVE PROCEDURES. AETNA HEALTH INC. CUSTOMER SERVICES PROFESSIONALS HAVE ACCESS TO TRANSLATION SERVICES THROUGH THE AT&T LANGUAGE LINE. A TDD# FOR THE HEARING IMPAIRED IS ALSO AVAILABLE.

Important

Unless otherwise specifically provided, no Member has the right to receive the benefits of this plan for health care services or supplies furnished following termination of coverage. Benefits of this plan are available only for services or supplies furnished during the term the coverage is in effect and while the individual claiming

the benefits is actually covered by the Group Agreement. Benefits may be modified during the term of this plan as specifically provided under the terms of the Group Agreement or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply for services or supplies furnished on or after the effective date of the modification. There is no vested right to receive the benefits of the Group Agreement.

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

TABLE OF CONTENTS

HMO PROCEDURE

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

At the time of enrollment, each **Member** should select a **Participating Primary Care Physician (PCP)** from **HMO's** Directory of Participating Providers to access **Covered Benefits** as described in this **Certificate**. The choice of a **PCP** is made solely by the **Member**. If the **Member** is a minor or otherwise incapable of selecting a **PCP**, the **Subscriber** should select a **PCP** on the **Member's** behalf. Until a **PCP** is selected, benefits will be limited to coverage for **Emergency Medical conditions.**

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 the case of an **Emergency Medical Condition** 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 an **Emergency Medical Condition**.

D. **Changing a PCP.**

A **Member** may change their **PCP** at any time by calling the **Member** Services toll-free telephone number listed on the **Member's** identification card or by written or electronic submission of the **HMO's** change form. A **Member** may contact **HMO** to request a change form or for assistance in completing that form. The change will become effective upon **HMO**'s receipt and approval of the request.

E. **Continuity of Care.**

1. **HMO** shall notify a **Member** at least 30 days before the disenrollment of such **Member's PCP**. A **Member** may continue to be eligible for covered benefits, consistent with the terms of this **Certificate**, by such **PCP** for at least 30 days after the **PCP** is disenrolled, except for disenrollment for quality-related reasons or for fraud. A **Member** may change their **PCP** at any

time by calling the **Member** Services toll-free telephone number listed on their identification card or by written or electronic submission of the **HMO** 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.

2. Coverage is provided for any female **Member** who is in her second or third trimester of pregnancy and whose **Provider** in connection with her pregnancy is involuntarily disenrolled, except for disenrollment for quality-related reasons or for fraud, to continue treatment with such **Provider**, consistent with the terms of this **Certificate**, for the period up to and including the **Member's** first postpartum visit.

3. Coverage is provided for a **Member** who is terminally ill and whose **Provider** in connection with such illness, is involuntarily disenrolled, except for disenrollment for quality-related reasons or for fraud, to continue treatment with said provider, consistent with the terms of this **Certificate**, until the **Member's** death.

4. Coverage is provided for **Covered Benefits** for up to 30 days from the effective date of coverage to a new **Member** for services rendered by a non-participating **Provider** if: (1) the **Member's** employer only offers the **Member** a choice of carriers in which said **Physician** is not a **Participating Provider**, and (2) said **Physician** is providing the **Member** with an ongoing course of treatment or is the **Member's PCP**. With respect to a new **Member** in her second or third trimester of pregnancy, this provision shall apply to services rendered through the first postpartum visit. With respect to a new **Member** with a terminal illness, this provision shall apply to services rendered until death.

HMO may condition coverage of continued treatment by a **Provider** under sections 1. through 4. above, inclusive, upon the **Providers'** agreeing (1) to accept reimbursement from **HMO** at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to the **Member** in an amount that would exceed the cost sharing that could have been imposed if the **Provider** had not been disenrolled; (2) to adhere to the quality assurance standards of **HMO** and to provide **HMO** with necessary medical information related to the care provided; and (3) to adhere to **HMO**'s policies and procedures, including procedures regarding **Referrals**, obtaining prior authorization and providing services pursuant to a treatment plan, if any, approved by **HMO**. Nothing in this subsection shall be construed to require the coverage of services that would not have been covered if the **Provider** involved remained a **Participating Provider**.

F. **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 Grievance Procedure section of this **Certificate**.

G. **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**.

ELIGIBILITY AND ENROLLMENT

A. **Eligibility**.

1. To be eligible to enroll as a **Subscriber**, an individual must:

   a. meet all applicable eligibility requirements agreed upon by the **Contract Holder** and **HMO**; and

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

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

   a. the legal spouse of a **Subscriber** under this **Certificate**; or

   b. a dependent unmarried child (including natural, foster, step, legally adopted children, children placed for adoption, a child under court order, dependents of dependents) who meets the eligibility requirements described in this **Certificate** and on the Schedule of Benefits.

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

B**.** **Enrollment.**

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

1. Newly Eligible Individuals and Eligible Dependents.

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

2. Open Enrollment Period.

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

3. Enrollment of Newly Eligible Dependents.

   a. Newborn Children.

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

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

b. Adopted Children.

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

4. Special Rules Which Apply to Children.

a. Qualified Medical Child Support Order.

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

b. Handicapped Children.

Coverage is available for a child who is chiefly dependent upon the **Subscriber** for support and maintenance, and who is 19 years of age or older but incapable of self-support due to mental or physical incapacity. The incapacity must have commenced prior to the age the dependent would have lost eligibility. In order to continue coverage for a handicapped child, the **Subscriber** must provide evidence of the child's incapacity and dependency to **HMO** within 31 days of the date the child's coverage would otherwise terminate. Proof of continued incapacity, including a medical examination, must be submitted to **HMO** as requested, but not more frequently than annually beginning after the two year period following the child's attainment of the age specified on the Schedule of Benefits. This eligibility provision will no longer apply on the date the dependent's incapacity ends.

5. Notification of Change in Status.

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

6. Special Enrollment Period.

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

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

An eligible individual or an eligible dependent may be enrolled during a special enrollment period, if requirements (a), (b), (c) and (d) are met:

a. the eligible individual or the eligible dependent was covered under another group health plan or other health insurance coverage when initially eligible for coverage under **HMO**;

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

c. the eligible individual or eligible dependent loses coverage under the other group health plan or other health insurance coverage for one of the following reasons:

   i. the other group health coverage is COBRA continuation coverage under another plan, and the COBRA continuation coverage under that other plan has since been exhausted; or

   ii. the other coverage is a group health plan or other health insurance coverage, and the other coverage has been terminated as a result of loss of eligibility for the coverage or employer contributions towards the other coverage have been terminated.

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

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

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

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

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

Special Enrollment Period When a New Eligible Dependent is Acquired:

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

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

- In the case of marriage, the first day of the first calendar month following the date the completed request for enrollment is received.

- In the case of a dependent's birth, adoption or placement for adoption, the date of such birth, adoption or placement for adoption.

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

C. **Effective Date of Coverage**.

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

Medical Necessity or Medically Necessary means health care services that are consistent with generally accepted principles of professional medical practice as determined by whether:

- the service is the most appropriate available supply or level of service for the insured in question considering potential benefits and harms to the individual;
- is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or
- for services and interventions not in widespread use, is based on scientific evidence.

HMO may develop guidelines to be used by **HMO** in determining if services are **Medically Necessary**. Any such guidelines used by **HMO** in determining if covered services or supplies are **Medically Necessary**, shall be, at a minimum:

- developed with input from practicing physicians in **HMO's** service area;
- developed in accordance with standards adopted by national accreditation organizations;
- updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practices;
- evidenced based, if practicable; and

- applied in a manner that considers the individual health care needs of the **Member**.

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

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

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

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

A. Primary Care Physician Benefits.

1. Office visits during office hours.

2. Home visits.

3. After-hours **PCP** services. **PCPs** are required to provide or arrange for on-call coverage 24 hours a day, 7 days a week. If a **Member** becomes sick or is injured after the **PCP's** regular office hours, the **Member** should:

   a. call the **PCP's** office; and

   b. identify himself or herself as a **Member**; and

   c. follow the **PCP's** or covering **Physician's** instructions.

   If the **Member's** injury or illness is an **Emergency Medical Condition**, 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 physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and development screening and assessment six times during the child's first year after birth, three times during the year annually until age six and tuberculin tests, hematocrit, hemoglobin or other appropriate blood test and urinalysis as recommended by a **Physician**, immunizations and booster doses of all immunizing agents used in child immunizations which conform to the standards of the Advisory Committee on Immunization Practices of the Centers for Disease Control, U.S. Department of Health and Human Services;

   b. newborn hearing screening test to be performed before the newborn infant is discharged from the **Hospital** or birthing center;

   c. routine physical examinations;

   d. 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;

e. routine hearing screenings;

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

g. routine vision screenings.

6. Injections, including allergy desensitization injections.

7. Casts and dressings.

8. Health Education Counseling and Information.

9. Early intervention services including occupational, physical and speech therapy, nursing care and psychological counseling upon referral by the **Primary Care Physician** for dependents from birth until thirty-nine (39) months of age, or until September 1 of the year of the recipient's third birthday if the recipient was born after April 1. Coverage is subject to the maximum, if any, shown on the Schedule of Benefits.

10. Enteral formulas for home use when the **Primary Care Physician** issues a written order indicating the medical necessity of the formula for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids. Coverage for inherited diseases of amino acids and organic acids shall include food products modified to be low protein in an amount not less than $2,500 per calendar year per **Member**, subject to applicable copayment.

11. Special medical formulas which are approved by the commissioner of the department of public health, prescribed by a physician, and are medically necessary for treatment of phenylketonuria, tyrosienmia, homocysinuria, maple syrup urine disease, propionic acidemia or methylmalonic acidemia in infants and children or medically necessary to protect the unborn fetuses of pregnant women with phenylketonuria.

12. Blood-glucose monitoring strips for home use for which a **Physician** has issued a written order and which are **Medically Necessary** for the treatment of insulin dependent diabetes.

B. Diagnostic Services Benefits.

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

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

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

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

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

3. cytologic screening, benefits shall provide for an annual cytologic screening for women eighteen years of age and older.

4. lead poisoning screening in accordance with the laws of the State of Massachusetts.

5. human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to establish such **Member's** bone marrow transplant donor suitability.

C. Specialist Physician and Health Professional Benefits.

Covered Benefits include outpatient and inpatient services.

Coverage is provided for pediatric specialty care, including mental health care, by persons with recognized expertise in specialty pediatrics to **Members** requiring such 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 an **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**.

D. Direct Access Specialist Benefits.

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

- Routine Gynecological Examination(s). Routine gynecological visit(s) and Pap smear(s), as well as **Medically Necessary** evaluations and resultant health care services for acute or emergency gynecological conditions. The maximum number of visits, if any, is listed on the Schedule of Benefits.

- Direct Access to Gynecologists. Coverage is provided for initial and subsequent treatment to female **Members** for obstetric or gynecological services determined by such **Participating** obstetrician, gynecologist, certified nurse midwife or family practitioner to be **Medically Necessary** as a result of such examination, for diagnosis and treatment of gynecological problems and maternity care.

  Coverage is provided for treatment to female **Members** for services performed by a Participating gynecologist or Participating Infertility Specialist for diagnosis and treatment of Infertility. Benefits include:

  i. initial evaluation, including history and physical and laboratory studies performed at the **Participating** laboratory designated by **HMO** to the **Member's PCP** or, if none has been designated to the **Member's PCP**, at any **Participating** laboratory;
  ii. evaluation of ovulatory function;
  iii. ultrasound of ovaries at a **Participating** radiology facility designated by **HMO** to the **Member's PCP** or, if none has been designated to the **Member's PCP**, at any **Participating** radiology facility;
  iv. post-coital test;
  v. hysterosalpingogram;
  vi. endometrial biopsy; and
  vii. hysteroscopy.

  Semen analysis is covered for a male **Member** with a **Referral** from his **PCP**.

- Routine Eye Examinations, including refraction, performed by a **Participating** ophthalmologist or optometrist, as follows:

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

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

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

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

E. Maternity Care and Related Newborn Care Benefits.

Outpatient and inpatient pre-natal and postpartum care and obstetrical services provided by **Participating Providers** are a **Covered Benefit**. The **Participating Provider** is responsible for obtaining any required pre-authorizations for all non-routine obstetrical services from **HMO** after the first prenatal visit.

Coverage does not include routine maternity care (including delivery) received while outside the **Service Area** unless the **Member** receives pre-authorization from **HMO**. As with any other medical condition, **Emergency Services** are covered when **Medically Necessary**.

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

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

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

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

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

F. Inpatient Hospital & Skilled Nursing Facility Benefits.

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

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

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

G. Transplant Benefits.

Transplants which are non-experimental or non-investigational are a **Covered Benefit**. Covered transplants must be ordered by the **Member's PCP** and **Participating Specialist Physician** and pre-authorized by **HMO**'s Medical Director. The transplant must be performed at **Hospitals** specifically approved and designated by **HMO** to perform these procedures. A transplant is non-experimental and non-investigational hereunder when **HMO** has determined, in its sole discretion, that the **Medical Community** has generally accepted the procedure as appropriate treatment for the specific condition of the **Member**. Covered transplants include bone marrow transplants for those **Members** who have been diagnosed with breast cancer that has progressed to metastatic disease and who have met the criteria established by the Department of Public Health. If a covered bone marrow transplant is not available from a **Participating Provider**, benefits will be paid at the **Participating Provider** level for such covered services rendered by a non-**Participating Provider**. Coverage for a transplant where a **Member** is the recipient includes coverage for the medical and surgical expenses of a live donor, to the extent these services are not covered by another plan or program.

H. Outpatient Surgery Benefits.

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

I. Substance Abuse Benefits.

A **Member** is covered for the following services as authorized and provided by **Participating Behavioral Health Providers**. (A **Member** may contact Member Services at the toll free telephone number on their **Member** ID Card.)

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

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

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

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

J. Mental Health Benefits.

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

1. Biologically Based Mental Illness

   Coverage shall be provided for the medical treatment and diagnosis of certain Biologically Based Mental Illnesses under the same terms and conditions and which are no less extensive than coverage provided for any other type of health care for physical illness. The following Biologically Based Mental Illnesses shall be covered:

   a. Schizophrenia;
   b. Schizoaffective disorder;
   c. Major depressive disorder;
   d. Bipolar disorder;
   e. Paranoia and other psychotic disorders;
   f. Obsessive-compulsive disorder;
   g. Panic disorder;
   h. Delirium and dementia;
   i. Affective disorders; and
   j. Any biologically-based mental disorders appearing in the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association (APA) that are scientifically recognized and approved by the commissioner of the Department of Mental Health in consultation with the commissioner of the Division of Insurance.

2. Rape Related Mental or Emotional Disorders

   Coverage shall be provided for the diagnosis and treatment of rape-related mental or emotional disorders to **Members** who are a victim of a rape or victim of an assault with intent to commit rape under the same terms and conditions and which are no less extensive than coverage provided for any other type of health care for physical illness; whenever the costs of such diagnosis and treatment exceed the maximum compensation awarded to such **Members**.

3. Children and Adolescents under the age of 19

   Benefits shall be covered under the same terms and conditions and which are not less extensive than coverage provided for any other type of health care for physical illness, for children and adolescents under the age of 19 for the diagnosis and treatment of non-biologically-based mental, behavioral or emotional disorders, as described in the most recent edition of the DSM, which substantially interfere with or substantially limit the functioning and social interactions of such a child or adolescent; provided, that said interference or limitation is documented by and the **Referral** for said diagnosis and treatment is made by the **Primary Care Physician**, primary pediatrician or a licensed mental health professional of such a child or adolescent or is evidenced by conduct, including, but not limited to: (1) an inability to attend school as a result of such a disorder, (2) the need to hospitalize the child or adolescent as a result of such a disorder, (3) a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others. **HMO** shall continue to provide such benefits to any adolescent who is engaged in an ongoing course of treatment beyond the adolescent's nineteenth birthday until said course of treatment is completed and while the benefit contract under which such benefits first became available remains in effect, or subject to a subsequent benefits contract which is in effect.

   If COBRA coverage is selected then coverage for all plan benefits will be available. If COBRA coverage is not selected, any **Premium** paid to continue the mental health benefits beyond age 19 will continue the mental health benefits only, and COBRA eligibility will not be extended.

4. Psychopharmacological Services/Neuropsychological Assessment Services

Coverage shall be provided for the diagnosis and treatment of Psychopharmacological Services/Neuropsychological Assessment Services under the same terms and conditions and which are no less extensive than coverage provided for any other type of health care for physical illness.

5. All Other Covered Mental Conditions

Coverage shall be provided for outpatient treatment for the diagnosis and treatment of all other covered mental conditions subject to the maximum number of visits, if any, shown on the Schedule of Benefits.

Coverage shall be provided for inpatient treatment for the diagnosis and treatment of all other covered mental conditions subject to the maximum number of days, if any, shown on the Schedule of Benefits. Inpatient benefits may be covered for medical, nursing, counseling or therapeutic services in an inpatient, non-hospital residential facility, appropriately licensed by the Department of Health or its equivalent.

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

Requests for a benefit exchange must be initiated by the **Member's Participating Behavioral Health Provider** under the guidelines set forth by the **HMO**. **Member** must utilize all outpatient mental health benefits, if any, available under the **Certificate** and pay all applicable **Copayments** before an inpatient and outpatient visit exchange will be considered. Request for exchange must be approved in writing by **HMO** prior to utilization.

7. The limitation on benefits for the treatment of substance abuse shall not apply when substance abuse treatment is rendered in conjunction with treatment for mental illness. Nor shall any substance abuse limitations impose or be construed to impose any restriction or limitation in connection with benefits for the treatment of mental illness.

8. **HMO** may require consent to the disclosure of information regarding services for mental disorders only to the same or similar extent in which **HMO** requires consent for the disclosure of information for other medical conditions.

K. Emergency Services/Urgent Care Benefits.

1. Emergency Care

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

A **Member** has the option of calling the local pre-hospital emergency medical service system by dialing the emergency telephone access number 911, or its local equivalent, whenever the **Member** is confronted with an **Emergency Medical Condition** which in the judgement of a prudent layperson would require pre-hospital **Emergency Services**.

The **Member** should notify their **Primary Care Physician** as soon as possible after **Emergency Services** or **Urgent Care** treatment. Notice given to **HMO**, designee or **Primary Care Physician** by the attending emergency care **Physician** shall satisfy this requirement.

After the **Member** has been stabilized for discharge or transfer, **HMO** may require the **Hospital** emergency department to contact a **Physician** on-call designated by **HMO** or its designee for authorization of post-stabilization services to be provided. The **Hospital** emergency department shall take all reasonable steps to initiate contact with **HMO** or its designee within 30 minutes of stabilization. Such authorization shall be deemed granted if **HMO** or its designee has not responded to said call within 30 minutes. Notwithstanding the foregoing provisions, in the event the attending **Physician** and said on-call **Physician** do not agree on what constitutes appropriate medical treatment, the opinion of the attending **Physician** shall prevail and such treatment shall be considered appropriate treatment for an **Emergency Medical Condition**, provided, that such treatment is consistent with generally accepted principles of professional medical practice and is a **Covered Benefit** under this **Certificate**.

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

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

Medical transportation is covered during an **Emergency Medical Condition**.

2. **Urgent Care**

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

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

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

L. Outpatient Rehabilitation Benefits.

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

1. A limited course of cardiac rehabilitation following an inpatient hospital stay and outpatient cardiac rehabilitation benefits meeting standards of the Department of Public Health if initiated within 26 weeks after the diagnosis of the disease, is covered when **Medically Necessary** following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction. The coverage limits do not apply if part of an approved home health care program.

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

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

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

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

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

M. Home Health Benefits.

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

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

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

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

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

5. Nutritional consultation services to the extent they are considered to be a **Medically Necessary** component of nursing or physical therapy.

6. The use of durable medical equipment and supplies to the extent they are considered to be a **Medically Necessary** component of nursing or physical therapy.

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

N. Hospice Benefits.

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

Coverage is not provided for funeral arrangements, pastoral counseling, and financial or legal counseling. Homemaker or caretaker services, and any service not solely related to the care of the **Member**, including but not limited to, sitter or companion services for the **Member** or other **Members** of the family, transportation, house cleaning, and maintenance of the house are not covered. Coverage is not provided for **Respite Care**.

O. Prosthetic Appliances.

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. 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**. Coverage includes therapeutic/molded shoes and shoe inserts for the treatment of insulin-dependent, insulin-using, gestational and non-insulin-dependent diabetes to the extent those items are covered by Medicare. **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.

Coverage is provided for expenses for scalp hair prostheses worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia; provided, however, that such coverage shall be subject to a written statement by the treating **Physician** that the scalp hair prosthesis is **Medically Necessary**. Coverage is subject to the same limitations and guidelines as other prostheses, and shall not be less than $350 per calendar year.

P. Injectable Medications Benefits.

Injectable medications, including those medications intended to be self administered, are a **Covered Benefit** when an oral alternative drug is not available, unless specifically excluded as described in the Exclusions and Limitations section of this **Certificate**. Medications must be prescribed by a **Provider** licensed to prescribe federal legend prescription drugs or medicines, and pre-approved 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 one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) and the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer reviewed journal.

Q. Comprehensive Infertility Services.

The following **Infertility** services are covered upon prior authorization by **HMO** when provided by a **Participating** gynecologist or a **Participating Infertility Specialist**:

1. ovulation induction with menotropins; subject to Medical Necessity;

2. artificial insemination (AID, AIH, IUI); subject to Medical Necessity; and

3. **Infertility** surgery (diagnostic or therapeutic).

In order to be eligible for Comprehensive Infertility Services, a **Member** must be covered under the **Certificate** as a **Subscriber** or a **Covered Dependent**; and

a. have a condition that is a demonstrated cause of **Infertility** as recognized by a **Participating** gynecologist or **Participating Infertility Specialist**; or

b. be unable to conceive after a year or more of exposure to sperm or 12 cycles of artificial insemination (for **Members** less than 35 years of age) or be unable to conceive after six months or more of exposure to sperm or 6 cycles of artificial insemination (for **Members** 35 years of age or older).

R. 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.

S. Additional Benefits.

- Coverage is provided for insulin pumps and insulin pump supplies under the medical portion of this **Certificate**, subject to the applicable medical copayment. However, if coverage is provided for Durable Medical Equipment or Pharmacy, coverage for insulin pumps and insulin pump supplies will be subject to the lower of the Durable Medical Equipment or Pharmacy copayment.

- **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,** an annual maximum out-of-pocket payment, and an 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**, including orthotics, and voice-synthesizers and visual magnifying aids for the treatment of insulin-dependent, insulin-using, gestational and non-insulin-dependent diabetes, 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,** an annual maximum out-of-pocket payment, and an annual maximum benefit may apply to this service. Refer to the Schedule of Benefits attached to this **Certificate**.

EXCLUSIONS AND LIMITATIONS

A. **Exclusions.**

The following are not **Covered Benefits** except as described in the Covered Benefits section of this **Certificate** or by rider(s) and/or an 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 other than blood derived clotting factors, the collection or storage of blood plasma, the cost of receiving the services of professional blood donors, apheresis or plasmapheresis. Only administration, processing of blood, processing fees, and fees related to autologous blood donations are covered.
- Care for conditions that state or local laws require to be treated in a public facility, including but not limited to, mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- **Cosmetic Surgery**, or treatment relating to the consequences of, or as a result of, **Cosmetic Surgery**, other than **Medically Necessary Services**. This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty, except when determined to be **Medically Necessary** by an **HMO** Medical Director, is not covered. This exclusion does not apply to surgery to correct the results of injuries causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.
- Costs for services resulting from the commission of, or attempt to commit a felony by the **Member**.
- Court ordered services, or those required by court order as a condition of parole or probation.
- **Custodial Care**.

- Dental services, including but not limited to, services related to the care, filling, removal or replacement of teeth, and treatment of injuries to or diseases of the teeth, dental services related to the gums, apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, alveolectomy, augmentation and vestibuloplasty treatment of periodontal disease, false teeth, prosthetic restoration of dental implants, and dental implants. This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors, and orthodontogenic cysts.

- Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, learning disabilities, or developmental delays. Special education, including lessons in sign language to instruct a **Member**, whose ability to speak has been lost or impaired, to function without that ability, are not covered. This exclusion does not include early intervention services as outlined in the covered benefits section of this **Certificate**.

- **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 does not apply to bone marrow transplants for treatment of breast cancer.

  This exclusion does 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;

  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; or

  4. in which the off-label uses are to treat cancer and HIV/AIDS.

- Hair analysis.

- 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.

- **Infertility** and **Advanced Reproductive Technology Services**, except as otherwise covered under this **Certificate**. This exclusion includes, but is not limited to:

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

2. services for females with FSH levels greater than 19 mIU/ml on Day 3 of the menstrual cycle;

3. artificial insemination for females without male partners attempting to become pregnant who have not had at least 12 cycles of donor insemination (6 cycles for **Members** age 35 or older) prior to enrolling in the **Infertility Program**;

4. all charges associated with a gestational carrier program (surrogate parenting) for the **Member** or the gestational carrier;

5. any service provided by a non-participating **Provider**, and any services provided without a prior referral, pre-authorization and claim authorization from the **Infertility Case Management Unit**;

6. home ovulation prediction kits;

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

8. fees associated with donor egg programs;

9. reversal of sterilization surgery;

10. Coverage for services received by a spouse who is not a **Member**; and

11. **ART Services** that are not reasonably likely to result in success.

- 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.

- Outpatient supplies, including but not limited to, medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings, except coverage shall be provided for glucose monitoring strips as provided in the **Covered Benefits** section of this **Certificate**.

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

- Personal comfort or convenience items, including those services and supplies not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other like items and services.

- Prescription or non-prescription drugs and medicines, except as provided on an inpatient basis. This exclusion shall not apply to coverage provided for non-experimental oral cancer drugs approved by the FDA when prescribed for anti-cancer chemotherapy by a **Physician** and obtained through a **Participating Provider**.

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

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

- In the absence of a diagnosed behavioral health disorder, religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling, and sex therapy.

- Reversal of voluntary sterilizations, including related follow-up care and treatment of complications of such procedures.

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

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

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

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

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

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

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

- Specific injectable drugs, including:

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

2. needles, syringes and other injectable aids;

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

4. drugs related to contraception, and performance enhancing steroids;

5. the off-label use of injectable drugs or medications. This provision does not exclude coverage of those prescribed drugs approved by the FDA for the treatment of cancer and HIV/AIDS for which the drug has not been approved by the FDA, provided however that such drug must be recognized for treatment of cancer and HIV/AIDS for which the drug has been endorsed in one of the following established reference compendia: 1) the American Medical Association Drug Evaluations; 2) the American Hospital Formulary Service Drug Information; 3) the United States Pharmacopoeia Drug Information; or 4) recommended by review article or editorial comment in a major peer review professional journal for the treatment of a specific type of cancer; diseases. Any drug which the FDA has determined to be contra-indicated for treatment of the specific type of cancer for which the drug has been prescribed is not covered.

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

- Surgical operations, procedures or treatment of obesity, except when specifically approved by **HMO**.

- 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 prior **Referral** issued by the **Member's PCP** or certified by **HMO**. This exclusion does not apply to an **Emergency Medical Condition**, in an **Urgent Care** situation, or when it is a direct access **Specialist** benefit.

- Vision care services and supplies, including orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) and radial keratotomy, including related procedures designed to surgically correct refractive errors.

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

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

- Family planning services.

- Hearing aids.

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

B. **Limitations.**

- In the event there are two or more alternative **Medical Services** which in the sole judgment of **HMO** are equivalent in quality of care, **HMO** reserves the right to provide coverage only for the least costly **Medical Service**, as determined by **HMO**, provided that **HMO** approves coverage for the **Medical Service** or treatment in advance.

- Determinations regarding eligibility for benefits, coverage for services, benefit denials and all other terms of this **Certificate** are at the sole discretion of **HMO,** subject to the terms of this **Certificate**.

- Coverage under this benefit will terminate immediately upon a **Member's** termination of coverage under the **Certificate**, subject to group continuation coverage requirements under COBRA or state continuation laws.

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

TERMINATION OF COVERAGE

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

A. Termination of Subscriber Coverage.

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

1. employment terminates;

2. the **Group Agreement** terminates; **HMO** will notify **Subscribers** of termination of **Group Agreement** for non-payment of **Premium**.

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 on the Schedule of Benefits;

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

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

C. Termination For Cause.

HMO may terminate coverage for cause:

upon 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**.

1. 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.

2. 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**.

3. Upon commission of acts of physical or verbal abuse by the **Member** which pose a threat to providers or other **Members** of **HMO** and which are unrelated to the physical or mental condition of the Member.

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

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

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

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

CONTINUATION AND CONVERSION

A. **COBRA Continuation Coverage.**

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

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

1. Minimum Size of Group:

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

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

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

3. Loss of coverage due to:

   a. divorce or legal separation, or

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

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

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

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

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

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

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

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

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

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

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

5. Extensions of Coverage Periods:

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

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

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

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

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

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

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

B. **Continuation under Massachusetts State Law.**

1. Continuation of coverage after death or layoff

If **Member's** coverage under this **Certificate** would terminate because of involuntary layoff or death, the coverage originally provided under this Certificate for the **Member**, his/her spouse and dependents shall be continued as provided herein for a period of 39 weeks from the date of such ineligibility or until such **Member**, his/her spouse and dependents become eligible for benefits under another group plan, whichever occurs first, but in no even shall continuation period exceed the period during which the **Member** was most recently covered under this **Certificate**.

The employer or policyholder shall notify the involuntary laid-off **Member**, surviving spouse of a deceased **Member** and dependents of their eligibility to continue participation under this **Certificate**. The involuntary laid-off member, surviving spouse of a deceased **Member** and dependents may elect to continue participation under this **Certificate** by giving at least 30 days written notice thereof to the employer or policyholder. Such **Member** or surviving spouse or dependents, as the case may be, shall be responsible for the payment of the whole **Premium** due for such coverage, including any and all amounts normally paid by the employer as employee's benefits, to the employer or policyholder throughout the extension period.

After timely receipt of the **Premium** payment from the responsible individual, if the employer or policyholder fails to make payment to **HMO** with the result that coverage is terminated, the employer or policyholder shall be liable for benefits to the same extent as **HMO** would have been liable if coverage had not been terminated.

Timely receipt of **Premium** payment shall mean the employer's or policyholder's receipt of the **Premium** for the extended coverage from such **Member**, surviving spouse or dependent as the case may be within the dates or by the date indicated by the employer or policyholder at the time of the election of extended coverage. Failure to give such notice or to make such **Premium** payment as hereinabove provided shall constitute a waiver of option to have such extended coverage.

2. Former Spouses.

If a **Member's** coverage under this **Certificate** would otherwise terminate due to divorce or legal separation from the **Subscriber**, such **Member** may continue coverage under this **Certificate** without additional **Premium** until the remarriage of such **Member** unless the divorce or separation judgment specifically states otherwise. Such **Member** is required to live or work in the **HMO Service Area** and obtain covered services according to the terms of this **Certificate** to retain eligibility for coverage. Continuation of coverage shall be at the group **Premium** rate. **Member** is responsible for payment of the applicable **Premium**.

In the event of the remarriage of the **Subscriber**, the former spouse thereafter shall have the right, if so provided in said judgment, to convert to individual membership in the group.

3. Termination due to plant closing.

In the event that coverage under this **Certificate** terminates due to termination of employment because of a plant closing or partial closing, the coverage under this **Certificate** for such **Subscriber** and the **Subscriber's** dependents, if any, shall continue for a period of 90 days from the date coverage would otherwise terminate or until **Subscriber** and the **Subscriber's** dependents, if any, become eligible for benefits under another group health plan.

C. **Extension of Benefits While Member is Receiving Inpatient Care.**

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

1. the date of discharge from such inpatient stay; or

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

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

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

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

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

D. **Conversion Privilege.**

This subsection does not continue coverage under the **Group Agreement**. It permits the issuance of an individual health care coverage agreement (conversion coverage) under certain conditions.

Conversion is not initiated by **HMO**. The conversion privilege set forth in this section 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 one 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 the Eligibility and Enrollment section of this **Certificate**, 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 the Eligibility and Enrollment section of this **Certificate** because of the **Member's** age or the death or divorce of **Subscriber**; or

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

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

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

2. A spouse has the right to convert upon the death of or divorce from the **Subscriber** and a **Covered Dependent** child has the right to convert upon reaching the age limit or upon death of the **Subscriber** (subject to the ability of minors to be bound by contract).

UTILIZATION REVIEW

A. Utilization Review Appeal Procedures

HMO shall maintain and make available procedures for providing notification of its determinations regarding certification as follows:

1. **HMO** shall make an initial determination regarding a proposed admission, procedure or service that requires such a determination within 2 working days of obtaining all necessary information.

   a) In the case of a determination to approve an admission, procedure or service, **HMO** shall notify the **Provider** rendering the service by telephone within 24 hours, and shall provide written electronic confirmation of the telephone notification to the **Member** and the **Provider** within 2 working days thereafter.

   b) In the case of an adverse determination, **HMO** shall notify the **Provider** rendering the service by telephone within 24 hours, and shall provide written or electronic confirmation of the telephone notification to the **Member** and the **Provider** within 1 working day thereafter.

2. **HMO** shall make a concurrent review determination within 1 working day of obtaining all necessary information.

   a. In the case of a determination to approve an extended stay or additional services, **HMO** shall notify by telephone the **Provider** rendering the service within 1 working day, and shall provide written or electronic confirmation to the **Member** and the **Provider** within 1 working day thereafter.

   b. In the case of an adverse determination, **HMO** shall notify by telephone the **Provider** rendering the service within 24 hours, and shall provide written or electronic notification to the **Member** and the **Provider** within 1 working day thereafter. The service shall be continued without liability to the **Member** until the **Member** has been notified of the determination.

3. **HMO** shall give a **Provider** treating a **Member** an opportunity to seek reconsideration of an adverse determination from a clinical peer reviewer in any case involving an initial determination or a concurrent review determination. The reconsideration process shall occur within 1 working day of the receipt of the request and shall be conducted between the **Provider** rendering the service and the clinical peer reviewer or a clinical peer designated by the clinical peer reviewer if said reviewer cannot be available within 1 working day. If the adverse determination is not reversed by the reconsideration process, the **Member**, or the **Provider** on behalf of the **Member**, may pursue the grievance process.

GRIEVANCE PROCEDURE

The following procedures govern complaints, grievances, and grievance appeals made or submitted by Members. All the rights of the Member also extend to the Member's authorized representative, which includes a Member's guardian, conservator, holder of a power of attorney, health care agent designated

pursuant to the law, family member, or other person authorized by the Member in writing or by law with respect to a specific grievance or external review, provided that if the Member is unable to designate a representative, where such designation would otherwise be required, a conservator, holder of a power of attorney, or family member in that order of priority may be the Member's representative or appoint another responsible party to serve as the Member's authorized representative.

A. **Definitions**.

1. An "inquiry" is a **Member's** request for administrative service, information, or to express an opinion, including but not limited to, claims regarding scope of coverage for health services, denials, cancellations, terminations or renewals, and the quality of services provided. An inquiry does not include an adverse determination.

2. A "grievance" is a complaint submitted to the **HMO** by telephone, in person, by mail, or by electronic means, which has been initiated by a **Member**, or on behalf of the **HMO** with the consent of the **Member**, concerning any aspect or action of the **HMO** relative to the **Member**, including, but not limited to, review of adverse determinations regarding scope of coverage, denial of services, quality of care and administrative operations.

B. **Inquiry Process**

The **Inquiry** Process is a process prior to the grievance process during which **HMO** may attempt to answer questions and/or resolve concerns communicated on behalf of the **Member** to the **Member's** satisfaction within three business days. This process shall not be used for review of an adverse determination which must be reviewed through the internal grievance process.

HMO will address any inquiry as expeditiously as possible, and provide a call back within 24 hours. If a resolution is not attainable within the required 3 business days, the inquiry will, at the option of the **Member**, be subject to the internal grievance process. A **Member** whose inquiry has not been explained or resolved to the **Member's** satisfaction within 3 business days of the inquiry, has the right to have the inquiry processed as an internal grievance at his/her option, including reduction of an oral inquiry to writing by **HMO**, written acknowledgement and written resolution of the grievance.

C. **Grievance Review**.

1. A written notice shall be sent by **HMO** to the **Member**:

   a. acknowledging receipt of an oral grievance within 48 hours and all other grievances within 15 days; and

   b. inviting the **Member** to provide any additional information to assist **HMO** in handling and deciding the grievance; and

   c. informing the **Member** of the **Member's** right to have an uninvolved **HMO** representative assist the member in understanding the grievance process; and

   d. informing the **Member** as to when a response should be forthcoming.

2. The Grievance Coordinator deciding the grievance shall not be any person who made the initial decision regarding the claim, or any person with previous involvement with the grievance. The Grievance Coordinator shall review and decide the grievance within 30 days of receipt unless there is mutual written agreement by **HMO** and **Member** to extend the 30 day time period. If additional information is required and the **Member** does not agree to an extension, **HMO** shall make a decision based on the information available. When a grievance requires the review of

medical records, the 30 business day period will not begin to run until the **Member**, or the **Member's** authorized representative submits a signed authorization for release of medical records and treatment information. In the event the signed authorization is not provided by the **Member** or the **Member's** authorized representative, if any, within 30 business days of the receipt of the grievance, **HMO** may, in its discretion, issue a resolution of the grievance without review of some or all of the medical records.

In at least one level of review of a grievance of adverse determination the grievance shall be reviewed with the participation of an individual who is an actively practicing health care professional in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment that is the subject of the grievance.

The 30 business day time period for written resolution of a grievance that does not require a review of medical records begins:

a. On the day immediately following 3 business days if an inquiry has not been addressed within 3 days; or

b. On the day the **Member** or the **Member's** authorized representative, if any, notifies the **HMO** that they are not satisfied with the response to an inquiry, if the response to the inquiry is provided earlier than 3 business days.

3. A written notice stating the result of the review by the Grievance Coordinator shall be forwarded by **HMO** to the **Member** within 30 days of receipt of the grievance. Such notice shall include:

a. a description of the Coordinator's understanding of the **Member's** grievance as presented to the Grievance Coordinator (i.e., dollar amount of the disputed issue, medical facts in dispute, etc.); and

b. the Coordinator's decision in clear terms, including the contract basis or medical rationale, as applicable, in sufficient detail for the **Member** to respond further to **HMO's** position (i.e., the **Member** did not contact the **PCP**, the services were non-emergency services as identified in the medical report, the services were not covered by the **Certificate**, etc.); and

c. a substantive clinical justification therefore that is consistent with generally accepted principles of professional medical practice, that shall at a minimum:

1) identify the specific information upon which the adverse determination was based;
2) discuss the **Member's** presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria;
3) specify alternative treatment options covered by **HMO**, if any;
4) reference and include applicable clinical practice guidelines and review criteria; and
5) notify the **Member** or the **Member's** authorized representative of the procedures for requesting external review.

d. citations to the evidence or documentation used as the basis for the decision (i.e., reference to the **Certificate**, medical records, etc.); and

e. a statement indicating:

i. that the decision of the Grievance Coordinator will be final and binding unless the **Member** appeals in writing to the Grievance Appeal Committee within 30 days of the date of the notice of the decision of the Grievance Coordinator; and

ii. a description of the process of how to appeal to the Grievance Appeal Committee.

4. A **Member** may contact Member Services at the toll-free telephone number on their ID Card for assistance in resolving grievances. A **Member** may also contact the **Office of Patient Protection** at their toll-free number (1-800-436-7757), facsimilie (617-624-5046) or via the internet site www.state.ma.us/dph

5. A grievance not properly acted on by **HMO** within the time limits stated above shall be deemed resolved in favor of the **Member**. Time limits include any extensions made by mutual written agreement of the **Member** or the **Member**'s authorized representative, if any, and **HMO**.

6. If a grievance is filed concerning the termination of ongoing coverage or treatment, the disputed coverage or treatment shall remain in effect at the **HMO's** expense through completion of the internal grievance process, regardless of the final internal grievance decision. Ongoing coverage or treatment include only that medical care that, at the time it was initiated, was authorized by **HMO** and does not include medical care that was terminated pursuant to a specific time or episode-related exclusion from the **Member's** contract for benefits.

D. **Appeal Hearing**.

1. Within 15 days of receipt of a written appeal by the Grievance Appeal Committee, **HMO** shall provide the **Member** filing the appeal with the procedures governing appeals before the Grievance Appeal Committee. The **Member** shall be notified of the **Member's** right to have an uninvolved **HMO** representative available to assist the **Member** in understanding the appeal process.

2. The Grievance Appeal Committee shall be established by the Board of Directors of the **HMO** and shall be comprised of three members, one of whom shall be a non-employee subscriber of the **HMO**. The Grievance Appeal Committee shall not include any person previously involved with the grievance. An **HMO** Medical Director may serve as a member of the Committee if the Medical Director was not previously involved with the grievance.

3. The Grievance Appeal Committee shall hold appeal hearings in **HMO** offices on a certain day each month to consider all appeals filed seven business days or more in advance of the hearing day. In the event a **Member** is unable to attend the hearing on the scheduled hearing day, the **Member** may request that their appeal be heard on the next scheduled hearing day. In no case will a decision take longer than 30 days unless both parties agree to waive the 30 day requirement.

4. The **Member** shall have the right to attend the appeal hearing, question the representative of **HMO** designated to appear at the hearing and any other witnesses, and present their case. The **Member** shall also have the right to be assisted or represented by a person of the **Member's** choice, and submit written material in support of their grievance. The **Member** may bring a **Physician** or other expert(s) to testify on the **Member's** behalf. **HMO** shall also have the right to present witnesses. Counsel for the **Member** may present the **Member's** case and question witnesses; if the **Member** is so represented, **HMO** may be similarly represented by counsel. The Grievance Appeal Committee shall have the right to question the **HMO** representative, the **Member** and any other witnesses.

5. The appeal hearing shall be informal. The Grievance Appeal Committee shall not apply formal rules of evidence in reviewing documentation or accepting testimony at the hearing. The Chair of

the Grievance Appeal Committee shall have the right to exclude redundant testimony or excessive argument by any party or witness.

6. A written record of the appeal hearing shall be made by stenographic transcription. All testimony shall be under oath.

7. Before the record is closed, the Chair of the Grievance Appeal Committee shall ask both the **Member** and the **HMO** representative (or their counsel) whether there is any additional evidence or argument which the party wishes to present to the Grievance Appeal Committee. Once all evidence and arguments have been received, the record of the appeal hearing shall be closed. The deliberations of the Grievance Appeal Committee shall be confidential and shall not be transcribed.

8. The Grievance Appeal Committee shall render a written decision within 30 working days of the conclusion of the appeal hearing. The decision shall contain:

   a. a statement of the Grievance Appeal Committee's understanding of the nature of the grievance and the material facts related thereto; and

   b. the Grievance Appeal Committee's decision and rationale; and

   c. a summary of the evidence, including necessary documents supporting the decision; and

   d. a statement of the **Member's** right to appeal an adverse determination to the **Office of Patient Protection**, with the phone number and complete address of the **Office of Patient Protection**.

E. **Reconsideration**

HMO may offer to the Member or the Member's authorized representative, if any, the opportunity for reconsideration of HMO's final adverse determination where relevant medical information:

1. was received too late to review within the 30 business day time limit; or

2. was not received but is expected to become available within a reasonable time period following the written resolution.

When a **Member** or **Member's** authorized representative, if any, chooses to request reconsideration, **HMO** must agree in writing to a new time period for review, but in no event greater than 30 business days from the agreement to reconsider the grievance. The time period for requesting external review shall begin to run on the date of the resolution of the reconsidered grievance.

F. **Expedited Grievance Review Procedures.**

1. In the event the **Member** is a **Hospital** inpatient, **Member** shall receive a written resolution of an expedited review of the grievance prior to **Hospital** discharge.

2. In the event the grievance is of an emergent or urgent nature where the **Physician** believes that denial of coverage for a **Medically Necessary** service would cause serious harm to the **Member**, an **HMO** Medical Director shall review the matter as soon as possible or within 48 hours, and communicate a decision to the **Member** by telephone. In the case of durable medical equipment (DME), the **Physician** may request an automatic reversal earlier than 48 hours; however, the **Physician** must certify to the specific, immediate and severe harm that will result to the **Member** absent action within the 48 hour period.

3. Provisions for the automatic reversal of decisions denying coverage for services or durable medical equipment, pending the outcome of the internal grievance process, within 48 hours or earlier for durable medical equipment at the option of a physician responsible for treatment or proposed treatment of the covered patient of receipt of certification by said **Physician** that, in the **Physician's** option:

   a. the service or use of durable medical equipment at issue in a grievance is **Medically Necessary**;

   b. a denial of coverage for such services or durable medical equipment would create a substantial risk of serious harm to the **Member**; and

   c. such risk of serious harm is so immediate that the provision of such services or durable medical equipment should not await the outcome of the normal grievance process.

4. In the event the grievance requires specific action, and the **Member** or **HMO** believes serious medical consequences will arise in the near future, within up to 15 days from **HMO's** denial to pay for the provision of allegedly **Medically Necessary** covered health services, the **Member** shall receive an expedited review of the grievance.

5. In the event the **Member** has a terminal illness, an expedited review of the grievance will be completed within 5 days from the receipt of the grievance.

   If the expedited review process affirms the denial of coverage to a **Member** with a terminal illness, **HMO** shall provide the **Member**, within 5 business days of the decision (1) a statement setting forth the specific medical and scientific reasons for denying coverage; (2) a description of alternative treatment, services or supplies covered by **HMO**, if any; and (3) the procedure for the **Member** to request a conference.

   HMO shall schedule such conference within 10 days of receiving the request for a conference from a **Member**, at the conference the information provided to the **Member** pursuant to provisions (1) and (2) above shall be reviewed by the **Member** and a representative of the **HMO** who has authority to determine the disposition of the grievance. **HMO** shall permit attendance at the conference of the **Member**, a designee of the **Member** or both, or, if the **Member** is a minor or incompetent, the parent, guardian or conservator of the **Member** as appropriate. The conference shall be held within 5 business days if the treating **Physician** determines, after consultation with the **HMO's** Medical Director or designee, and based on standard medical practice, that the effectiveness of either the proposed treatment, services or supplies or any alternative treatment, services or supplies covered by **HMO**, would be materially reduced if not provided at the earliest possible date.

6. **HMO** will continue to pay for the **Covered Benefits** during pendency of the review.

G. **External Review Process.**

A **Member** who remains aggrieved by an adverse determination and has exhausted all remedies available from the formal internal grievance process, may seek further review of the grievance by a review panel established by the **Office of Patient Protection**. The request for an external review must be made within 45 days of receipt of the **HMO's** final adverse determination. For the purposes of this provision, an adverse determination is based upon a review of information provided by **HMO** to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other health care services, for failure to meet the requirements for coverage based on **Medical Necessity**, appropriateness of health care setting and level of care, or effectiveness.

A **Member** or the **Member's** authorized representative, if any, may request to have his or her request for review processed as an expedited external review.

1. Any request for an expedited external review shall contain a certification, in writing, from a **Physician**, that delay in the providing or continuation of health care services that are the subject of a final adverse determination, would pose a serious and immediate threat to the health of the **Member**.

2. Upon finding that a serious and immediate threat to the **Member** exists, the **Office of Patient Protection** shall qualify such request as eligible for an expedited external review.

3. A **Member** seeking a review shall pay a fee of $25.00, to the **Office of Patient Protection**, which shall accompany the request for a review. The fee may be waived by said office if it determines that the payment of the fee would result in an extreme financial hardship to the **Member**.

4. The remainder of the cost for an external review shall be borne by **HMO**. Upon completion of the external review, the **Office of Patient Protection** shall bill **HMO** the amount established pursuant to contract between the Department and the assigned external review agency minus the $25.00 fee, which is the **Member's** responsibility.

5. In connection with any request for an external review, **HMO** shall assure that the **Member**, and where applicable the **Member's** authorized representative, have access to any medical information and records relating to the insured, in the possession of **HMO** or under **HMO's** control.

6. If the subject matter of the external review involves the termination of ongoing services, the **Member** may appeal to the external review panel to seek the continuation of coverage for the terminated service during the period the review is pending. The review panel may order the continuation of coverage or treatment where it determines that substantial harm to the **Member's** health may result absent such continuation or for such other good cause as the review panel shall determine. Any such continuation of coverage shall be at the **HMO's** expense regardless of the final external review determination.

7. The decision of the review panel shall be binding.

The **Office of Patient Protection**, established by the Department of Public Health, is responsible for the administration and enforcement of certain Massachusetts Managed Care requirements. A **Member** may obtain the necessary forms by calling the **Office of Patient Protection** at its toll-free telephone number (1-800-436-7757), facsimile (617-624-5046) or via the internet site (www.state.ma.us/dph). A Member may also contact the Office of Patient Protection to obtain a report detailing, for the previous calendar year, the total number of:

a) a list of sources of independently published information assessing insureds' satisfaction and evaluating the quality of health care services offered by HMO;

b) the percentage of Physicians who voluntarily and involuntarily terminated participation contracts with the carrier during the previous calendar year for which such data has been compiled and the three most common reasons for voluntary and involuntary physician disenrollment;

c) the percentage of premium revenue expended by the carrier for health care services provided to insureds for the most recent year for which information is available; and

d) a report detailing, for the previous calendar year, the total number of:

    1. filed grievances, grievances that were approved internally, grievances that were denied internally, and grievances that were withdrawn before resolution; and

2. external appeals pursued after exhausting the internal grievances process and the resolution of all such appeals.

H. **Record Retention.**

HMO shall retain the records of all grievances for a period of at least 7 years.

I. **Fees and Costs.**

Nothing herein shall be construed to required HMO to pay counsel fees or any other fees or costs incurred by a **Member** in pursuing a grievance or appeal.

COORDINATION OF BENEFITS

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

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

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

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

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

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

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

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

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

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

2. is secondary to Medicare.

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

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

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

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

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

3. If there is not such a court decree:

   If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

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

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

The benefits of a plan which covers the person as a:

1. laid-off or retired employee; or

2. the dependent of such person;

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

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

2. a dependent of such person.

If the other plan does not have a provision:

1. regarding laid-off or retired employees; and

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

then the above paragraph will not apply.

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

If the other plan does not have a provision:

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

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

then the above paragraph will not apply.

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

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

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

1. Group or individual insurance.

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

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

Payment of Benefits.

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

Facility of Payment.

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

Recovery of Overpayments.

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

Medicare And Other Federal Or State Government Programs.

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

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

other documents as may be requested by **HMO** in order to obtain or assure reimbursement under Medicare or any other government programs for which **Members** are eligible.

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

1. Are covered under a program;

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

3. Have terminated coverage under a program; or

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

Active Employees and Their Dependents Who Are Eligible For Medicare.

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

Covered Persons Who Are Disabled or Who Have End Stage Renal Disease (ESRD).

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

Provision for Coordination with Medicare

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

SUBROGATION AND RIGHT OF RECOVERY

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

The **Member** specifically acknowledges **HMO's** right of subrogation. When **HMO** provides health care benefits for injuries or illnesses for which another party is or may be responsible, **HMO** shall be subrogated to the

Member's rights of recovery against any party to the extent of the full cost of all benefits provided by **HMO**. **HMO** may proceed against any party with or without the **Member's** consent.

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

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

A. Notify **HMO** promptly and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to injuries or illness sustained by the **Member** that may be the legal responsibility of another party; and

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

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

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

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

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

RESPONSIBILITY OF MEMBERS

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

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

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

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

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

GENERAL PROVISIONS

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

If any **Member** permits the use of the **Member's HMO** identification card by any other person, such card may be retained by **HMO**, and all rights of such **Member** and their **Covered Dependents**, if any, pursuant to this **Certificate** shall be terminated immediately, subject to the Grievance Procedure 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**. **Providers** are only required to provide the patient name, diagnosis, and date and type of service as a condition to receiving mental health benefits under 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. **Quality Assurance Programs.** **HMO** has developed a comprehensive Quality Improvement Program that places strict attention on quality measurement and improvement and is designed to identify and respond to the health care concerns of our **Members**. Some of our quality-focused initiatives include:

1. Routine monitoring of quality of service and care, including:

   - The performance of medical chart review audits in the office setting,
   - Medical director review of **Member** utilization patterns to determine prevalence of acute and chronic conditions, and the need for focused disease management programs,

- Comprehensive utilization management and case management programs,
- Review of survey results which assess **Member** and provider satisfaction levels, and
- Periodic analysis of provider availability and access.

2. **Provider** certification and re-certification, as well as quality performance-based **Physician** and facility contracting.

3. Adoption and use of practice guidelines, including preventive care recommendations.

4. Health promotion and wellness programs which seek to identify **Members** who may be considered high-risk, and which offer incentives to **Members** who participate and achieve predetermined goals in fitness, smoking-cessation, and weight-loss programs.

5. The use of an automated tracking system to monitor **Member** complaints and grievances which help identify opportunities to improve service levels.

6. Programs to monitor and address potential under-utilization, and denial or delay in providing needed services.

7. Measuring provider performance to improve the quality of care, assessing medical costs to improve the value of care, and delivering sophisticated and integrated data reporting products to customers.

8. A Quality Care Compensation System which rewards PCP's for delivering quality care in a cost-effective manner, including payment on a per **Member** per month basis ("capitation"), as well as quality incentives to satisfy **Member**, improve medical care, and participate in continuing medical education programs. Also, an additional component of overall compensation reflects how effectively the **Physician** manages the cost of hospital and specialist services and provides effective preventive care. Other **Providers** are compensated on discounted fee-for-service payment and other capitation arrangements.

9. Annual evaluation of the Quality Improvement Program, including voluntary review and accreditation by the National Committee for Quality Assurance (NCQA), an independent, not-for-profit organization dedicated to assessing and reporting on the quality of care and service delivered by managed care organizations.

A **Member** may contact Member Services at the toll-free telephone number on their ID Card to determine the status or outcome of the utilization review decision.

D. **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 Grievance Procedure 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.

E. **Assignment of Benefits.** All rights of the **Member** to receive benefits hereunder are personal to the **Member** and may not be assigned.

F. **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 this

Group Agreement. No action shall be brought after the expiration of 3 years after the time written submission of claim is required to be furnished.

G. **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-participating **Provider**, institution, facility or agency.

2. Neither the **Contract Holder** nor a **Member** is the agent or representative of **HMO**, its agents or employees, or an agent or representative of any **Participating Provider** or other person or organization with which **HMO** has made or hereafter shall make arrangements for services under this **Certificate**.

3. **Participating Physicians** maintain the physician-patient relationship with **Members** and are solely responsible to **Member** for all **Medical Services** which are rendered by **Participating Physicians**.

4. **HMO** cannot guarantee the continued participation of any **Provider** or facility with **HMO**. In the event a **PCP** terminates its contract or is terminated by **HMO**, **HMO** shall provide notification to **Members** in the following manner:

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

   b. services rendered by a **PCP** or **Hospital** to an enrollee between the date of termination of the Provider Agreement and five 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.

H. **Inability to Provide Service.** If due to circumstances not within the reasonable control of **HMO**, including but not limited to, major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of the Participating Provider Network, the provision of medical or **Hospital** benefits or other services provided under this **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.

I. **Confidentiality.** Information contained in the medical records of **Members** and information received from any **Provider** incident to the provider-patient relationship shall be kept confidential in accordance with applicable law. Information may be used or disclosed by **HMO** when necessary for a **Member's** care or treatment, the operation of **HMO** and administration of this **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 an up-to-date copy of **HMO's** Notice of Information Practices by calling the Member Services toll-free telephone number listed on the **Member's** identification card or by visiting **HMO's** website.

J. **Limitation on Services.** Except in cases of **Emergency Services** or **Urgent Care**, or as otherwise provided under this **Certificate**, services are available only from **Participating Providers** and **HMO** shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a

Member from any **Physician**, **Hospital**, **Skilled Nursing Facility**, home health care agency, or other person, entity, institution or organization unless prior arrangements are made by **HMO**.

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

L. This **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**.

M. **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**.

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

O. 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**.

P. 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; and there are no warranties, representations, or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth in this **Certificate**. No supplement, modification or waiver of this **Certificate** shall be binding unless executed in writing by authorized representatives of the parties.

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

R. 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.

S. **HMO** shall notify the group representative at least 60 days before the effective date of any material modifications in covered services, and will identify changes in clinical criteria, if applicable, and fully detail the effect of such changes, if any, to the personal liability of the **Member** for the cost of such changes.

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:

- **Advanced Reproductive Technology ("ART").**

  1. in vitro fertilization (IVF);
  2. zygote intra-fallopian transfer (ZIFT);
  3. gamete intra-fallopian transfer (GIFT);
  4. cryopreserved embryo transfers (FET); or
  5. intracytoplasmic sperm injection (ICSI) or ovum microsurgery.

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

  1. If a **Member** is confined in a private **Hospital** room, the difference between the cost of a semi-private room in the **Hospital** and the private room, (unless the patient's stay in the private **Hospital** room is **Medically Necessary** in terms of generally accepted medical practice, or one of the plans routinely provides coverage for private **Hospital** rooms) is not an **Allowable Expense**.

  2. If a **Member** is covered by 2 or more plans that compute their benefit payments on the basis of the **Reasonable Charge,** any amount in excess of the lowest of the **Reasonable Charges** for a specified benefit is not an **Allowable Expense.**

  3. If a **Member** is covered by 2 or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the lowest of the negotiated fees is not an **Allowable Expense**.

  4. If a **Member** is covered by one 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 lowest payment arrangement shall be the **Allowable Expense** for all plans.

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

- **ART Services**. **ART** services, products, or procedures that are **Covered Benefits** under the **Certificate** and/or this benefit.

- **Behavioral Health Provider.** A licensed mental health professional specializing in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, or a licensed nurse mental health clinical specialist providing diagnostic, therapeutic or psychological services for behavioral health conditions.

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

- **Contract Holder.** An employer or organization who agrees to remit the **Premiums** for coverage under the **Group Agreement** payable to **HMO**. The **Contract Holder** shall act only as an agent of **HMO Members** in the **Contract Holder's** group, and shall not be the agent of **HMO** for any purpose.

- **Contract Year.** A period of one year commencing on the **Contract Holder's Effective Date of Coverage** and ending at 12:00 midnight on the last day of the one year period.

- **Coordination of Benefits.** A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing the authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first. Refer to the Coordination of Benefits section of this **Certificate** for a description of the **Coordination of Benefits** provision.

- **Copayment.** The specified dollar amount or percentage required to be paid by or on behalf of a **Member** in connection with benefits, if any, as set forth in the Schedule of Benefits. **Copayments** may be changed by **HMO** upon 30 days written notice to the **Contract Holder**.

- **Copayment Maximum.** The maximum annual out-of-pocket amount for payment of **Copayments**, if any, to be paid by a **Subscriber** and any **Covered Dependents**.

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

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

- **Covered Benefits.** Those **Medically Necessary Services** and supplies set forth in this **Certificate**, which are covered subject to all of the terms and conditions of the **Group Agreement** and **Certificate**.

- **Creditable Coverage.** Coverage of the **Member** under a group health plan (including a governmental or church plan), a health insurance coverage (either group or individual insurance), Medicare, Medicaid, a military-sponsored health care (CHAMPUS), a program of the Indian Health Service, a State health benefits risk pool, the Federal Employees Health Benefits Program (FEHBP), a public health plan, and any health benefit plan under section 5(e) of the Peace Corps Act. **Creditable Coverage** does not include coverage only for accident; workers' compensation or similar insurance; automobile medical payment insurance; coverage for on-site medical clinics; or limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits that are provided in a separate policy.

- **Custodial Care.** Any type of care provided in accordance with Medicare guidelines, including room and board, that a) does not require the skills of technical or professional personnel; b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-hospital **Skilled Nursing Facility** care; or c) is a level such that the **Member** has reached the maximum level of physical or mental function and such person is not likely to make further significant improvement. **Custodial Care** includes, but is not limited to, any type of care where the primary purpose of the type of care provided is to attend to the **Member's** daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of this include, but are not

limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non infected, post operative or chronic conditions, preparation of special diets, supervision of medication which can be self-administered by the **Member**, general maintenance care of colostomy or ileostomy, routine services to maintain other service which, in the sole determination of **HMO**, 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**.

- **Eligible Employee.** An employee who works on a full-time basis with a normal work week of thirty or more hours, and includes an owner, a sole proprietor or a partner of a partnership; provided however, that such owner, sole proprietor or partner is included as an employee under a health care plan of an eligible small business but does not include an employee who works on a temporary or substitute basis and is hired to work for a period of not less than five months.

- **Emergency Medical Condition.** A medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the **Member** or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman as further defined in the Social Security Act.

- **Emergency Service.** Professional health services that are provided to treat an **Emergency Medical Condition**.

- **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 professionals including podiatrists, certified registered nurse anesthetists, nurse practitioners, psychologists, licensed independent clinical social workers, clinical specialist in psychiatric and mental health nursing and licensed health counselors, who are 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 Massachusetts corporation licensed by the Massachusetts Division of Insurance as a Health Maintenance Organization .

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

- **Home Health Services.** Those items and services provided by **Participating Providers** as an alternative to hospitalization, and approved and coordinated in advance by **HMO**.

- **Hospice Care.** A program of care that is provided by a **Hospital**, **Skilled Nursing Facility**, hospice, or a duly licensed Hospice Care agency, and is approved by **HMO**, and is focused on a palliative rather than curative treatment for **Members** who have a medical condition and a prognosis of less than 6 months to live.

- **Hospital(s).** An institution rendering inpatient and outpatient services, accredited as a **Hospital** by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by **HMO** as meeting reasonable standards. A **Hospital** may be a general, acute care, rehabilitation or specialty institution.

- **Infertile or Infertility.** The condition of a presumably healthy **Member** who is unable to conceive or produce conception after 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.

- **Infertility Case Management**. **A** program administered by **HMO** that consists of:

  1. evaluation of **Infertile Members'** medical records to determine whether **ART Services** are **Medically Necessary** and are reasonably likely to result in success;

  2. determination of whether **ART Services** are **Covered Benefits** for the **Member**;

  3. pre-authorization for **ART Services** by a **Participating ART Specialist** when **ART Services** are **Medically Necessary**, reasonably likely to result in success, and are **Covered Benefits**; and

4. case management for the provision of **ART Services**.

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

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

- **Medically Necessary, Medically Necessary Services, or Medical Necessity.** Health care services that are consistent with generally accepted principles of professional medical practice as determined by whether: (1) the service is the most appropriate available supply or level of service for the insured in question considering potential benefits and harms to the individual; (2) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or (3) for services and interventions not in widespread use, is based on scientific evidence.

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

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

- **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.

- **Office of Patient Protection**. The office in the Department of Public Health responsible for the administration and enforcement of certain Massachusetts Managed Care requirements.

- **Open Enrollment Period.** A period of not less than 10 consecutive working days, each calendar year, when eligible enrollees of the **Contract Holder** may enroll in **HMO** without a waiting period or exclusion or limitation based on health status or, if already enrolled in **HMO**, may transfer to an alternative health plan offered by the **Contract Holder**.

- **Partial Hospitalization.** The provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a **Hospital** or **Non-Hospital Facility** which is licensed as an alcohol or drug abuse or mental illness treatment program by the appropriate regulatory authority, and which is designed for a patient or client who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care.

- **Participating.** A description of a **Provider** that has entered into a contractual agreement with **HMO** for the provision of services to **Members**.

- **Participating ART Specialist**. A **Specialist** who has entered into a contractual agreement with **HMO** for the provision of **ART** services.

- **Physician.** A duly licensed member of a medical profession, who has an M.D. or D.O. degree, who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides **Medical Services** which are within the scope of the individual's license or certificate.

- **Premium(s).** The amount the **Contract Holder** or **Member** is required to pay to **HMO** to continue coverage.

- **Primary Care Physician (PCP).** A **Participating Physician** who supervises, coordinates and provides initial care and basic **Medical Services** as a general or family care practitioner, or in some cases, as an internist or a pediatrician to **Members**, initiates their **Referral** for **Specialist** care, and maintains continuity of patient care.

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

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

- **Referral.** Specific directions or instructions from a **Member's PCP,** in conformance with **HMO's** policies and procedures, that direct a **Member** to a **Participating Provider** for **Medically Necessary** care.

- **Respite Care.** Care furnished during a period of time when the **Member's** family or usual caretaker cannot, or will not, attend to the **Member's** needs.

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

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

- **Skilled Nursing Facility.** An institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing skilled nursing care and related services as a **Skilled Nursing Facility**, extended care facility, or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by **HMO** to meet the reasonable standards applied by any of the aforesaid authorities.

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

- **Subscriber.** A person who meets all applicable eligibility requirements as described in this **Certificate** and on the Schedule of Benefits, has enrolled in **HMO**, and is subject to **Premium** requirements as set forth in the Premiums section of the **Group Agreement**.

- **Substance Abuse.** Any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.

- **Substance Abuse Rehabilitation.** Services, procedures and interventions to eliminate dependence on or abuse of legal and/or illegal chemical substances, according to individualized treatment plans.

- **Totally Disabled or Total Disability.** A **Member** shall be considered **Totally Disabled** if:

    1. the **Member** is a **Subscriber** and is prevented, because of injury or disease, from performing any occupation for which the **Member** is reasonably fitted by training, experience, and accomplishments; or

2. the **Member** is a **Covered Dependent** and is prevented because of injury or disease, from engaging in substantially all of the normal activities of a person of like age and sex in good health.

- **Urgent Care.** Non-preventive or non-routine health care services which are **Covered Benefits** and are required in order to prevent serious deterioration of a **Member's** health following an unforeseen illness, injury or condition if: (a) the **Member** is temporarily absent from the **HMO Service Area** and receipt of the health care service cannot be delayed until the **Member** returns to the **HMO Service Area**; or, (b) the **Member** is within the **HMO Service Area** and receipt of the health care services cannot be delayed until the **Member's Primary Care Physician** is reasonably available.

AETNA HEALTH INC.
(MASSACHUSETTS)

EARLY INTERVENTION AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

Section A.9, **Primary Care Physician Benefits,** found in the **Covered Benefits** section of the **Certificate** of Coverage is hereby deleted and replaced with the following:

9. Covered expenses include **medically necessary** services and supplies provided by early intervention specialists who are working in early intervention programs certified by the department of public health upon referral by the **Primary Care Provider** for dependents from birth until thirty-six (36) months of age including; but not limited to:

- 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**;
- Clinical psychological tests; or treatment;
- Skilled nursing services; on a part-time or intermittent basis; given by a **R.N**. or by a **L.P.N.**

Early Intervention services are not subject to a **copay, coinsurance** or **deductible**.

The Early Intervention Services provision appearing in the Schedule of Benefits is hereby deleted and replaced with the following:

Early Intervention Services	**No deductible, coinsurance or copayment applies.**

AETNA HEALTH INC.
(MASSACHUSETTS)

AMENDMENT TO THE CERTIFICATE OF COVERAGE

Contract Holder Group Agreement Effective Date: January 1, 2013

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

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

2. All references to the "Utilization Review and Grievance Procedure" sections in the **Certificate** are hereby deleted and replaced by the following:

   "Claim Procedures/Complaints and Appeals"

3. The "Utilization Review and Grievance Procedure" Section(s) of the **Certificate** are hereby deleted and replaced by the following:

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.

The **HMO** will make a decision on the **Member's** claim. For urgent care claims and pre-service claims, the **HMO** will send the **Member** written notification of the determination, whether adverse or not adverse.

HMO shall make an initial Utilization Review determination regarding a proposed admission, procedure or service claim within two (2) working days of obtaining all necessary information. Necessary information shall include the results of any face-to-face clinical evaluation or second opinion that may be required. In the case of a determination to approve a Utilization Review admission, procedure or service, **HMO** shall notify the **Provider** rendering the service by telephone within 24 hours, and shall provide written or electronic confirmation of the telephone notification to the **Member** and the **Provider** within two (2) working days thereafter.

HMO shall make a concurrent Utilization Review determination within one (1) working day of obtaining all necessary information. In the case of a determination to approve a concurrent claim, **HMO** shall notify the **Provider** rendering the service by telephone within one (1) working day, and shall provide written or electronic confirmation to the **Member** and the **Provider** within one (1) working day thereafter. The written or electronic notification shall include the number of extended days or the next review date, the new total number of days or services approved, and the date of admission or initiation of services.

For other types of claims, the **Member** may only receive notice if the **HMO** makes an adverse determination.

A **Member** may contact Member Services at the toll-free telephone number on their ID card to determine the status or outcome of Utilization Review decisions.

Adverse Determinations.
Adverse determinations are decisions made by the **HMO** that result in denial, reduction, or termination of a benefit or the amount paid for it. It also means a decision not to provide a benefit or service. Adverse determinations can be made for one or more of the following reasons:

- **Utilization Review. HMO** determines that the service or supply is not **Medically Necessary** or is an E**xperimental or Investigational Procedures**;

- **No Coverage. HMO** determines that a service or supply is not covered by the plan. A service or supply is not covered if it is not included in the list of **Covered Benefits**;

- it is excluded from coverage;

- an **HMO** limitation has been reached; or

- **Eligibility. HMO** determines that the **Subscriber** or **Subscriber's Covered Dependents** are not eligible to be covered by the **HMO.**

The written notice of an adverse determination shall include a substantive clinical justification that is consistent with generally accepted principals of professional medical practice and shall, at a minimum, also provide the following important information that will assist the **Member** in making an **Appeal** of the adverse determination, if the **Member** wishes to do so:

(a) identify the specific information upon which the adverse determination was based;

(b) discuss the **Member's** presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria;

(c) specify any alternative treatment options covered by **HMO**, if any;

(d) reference and include applicable clinical practice guidelines and review criteria; and

(e) a clear, concise and complete description of the **HMO**'s formal internal **Appeal** process and the procedures for obtaining external review, including the procedure to request an expedited external review.

Written notice of an adverse determination will be provided to the **Member** within the following time frames. Under certain circumstances, these time frames may be extended. Please see the Complaint and Appeals section of this **Certificate** for more information about **Appeals**.

Utilization Review

HMO Timeframe for Notification of a Utilization Review Adverse Determination

Type of Claim	HMO Response Time from Receipt of Claim
Urgent Care Claim. A claim for medical care or treatment where delay could seriously jeopardize the life or health of the **Member**, the ability of the **Member** to regain maximum function; or subject the **Member** to severe pain that cannot be adequately managed without the requested care or treatment.	Telephone the **Provider** within 24 hours. Send written or electronic confirmation of the telephone notification to the **Member** and the **Provider** within one working day thereafter.
Proposed Admission, Procedure or Service. A claim for a benefit that requires pre-authorization of the benefit in advance of obtaining medical care.	Telephone the **Provider** within 24 hours. Send written or electronic confirmation of the telephone notification to the **Member** and the **Provider** within one working day thereafter.
Concurrent Care Claim Extension. A request to extend a course of treatment previously pre-authorized by **HMO**.	Telephone the **Provider** within 24 hours. Send written or electronic confirmation of the telephone notification to the **Member** and the **Provider** within one working day thereafter. The service shall be continued without liability to the **Member** until the **Member** has been notified of the determination.
Concurrent Care Claim Reduction or Termination. Decision to reduce or terminate a course of treatment previously pre-authorized by **HMO**.	Telephone the **Provider** within 24 hours. Send written or electronic confirmation of the telephone notification to the **Member** and the **Provider** within one working day thereafter. The service shall be continued without liability to the **Member** until the **Member** has been notified of the determination.
Post-Service Claim. A claim for a benefit that is not a proposed admission, procedure or service claim.	Within 30 calendar days

HMO shall give a **Provider** treating a **Member** an opportunity to seek reconsideration of a Utilization Review adverse determination from a clinical peer reviewer in any case involving an initial determination or a concurrent review determination. The reconsideration process shall occur within one (1) working day of the receipt of the request and shall be conducted between the **Provider** rendering the service and the clinical peer reviewer or a clinical peer designated by the clinical peer reviewer if the reviewer cannot be available within one (1) working day. If the reconsideration process does not reverse the Utilization Review adverse determination, the **Member**, or the **Provider** on behalf of the **Member**, may pursue the **Appeal** Process. The reconsideration process shall not be a prerequisite to the **Appeal** Process or an expedited **Appeal**.

Non-Utilization Review

HMO Timeframe for Notification of a Non-Utilization Review Adverse Benefit Determination

Type of Claim	HMO Response Time from Receipt of Claim
Urgent Care Claim. A claim for medical care or treatment where delay could seriously jeopardize the life or health of the **Member**, the ability of the **Member** to regain maximum function; or subject the **Member** to severe pain that cannot be adequately managed without the requested care or treatment.	As soon as possible but not later than 72 hours
Pre-Service Claim. A claim for a benefit that requires pre-authorization of the benefit in advance of obtaining medical care.	Within 15 calendar days
Concurrent Care Claim Extension. A request to extend a course of treatment previously pre-authorized by **HMO**.	If an urgent care claim, as soon as possible but not later than 24 hours. Otherwise, within 15 calendar days.
Concurrent Care Claim Reduction or Termination. Decision to reduce or terminate a course of treatment previously pre-authorized by **HMO**.	With enough advance notice to allow the **Member** to **Appeal**.
Post-Service Claim. A claim for a benefit that is not a pre-service claim.	Within 30 calendar days

COMPLAINTS AND APPEALS

HMO has procedures for **Members** to use if they are dissatisfied with a decision that **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 requests redress of an action, omission or policy of the **HMO**.
- **Appeal.** An **Appeal** is a request to the **HMO** to reconsider a **Complaint** or an adverse determination. The **Appeal** procedure for a **Complaint** or an adverse 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.

A. **Inquiries.**

The **Inquiry** Process is a process prior to the **Appeal** process during which **HMO** may attempt to answer questions and/or resolve concerns communicated on behalf of the **Member** to the **Member's** satisfaction within three business days. This process shall not be used for review of an adverse determination, which must be reviewed through the **Appeal** process.

HMO will address any **Inquiry** as expeditiously as possible, and provide a call back within 24 hours. A **Member** whose **Inquiry** has not been explained or resolved to the **Member's** satisfaction within three (3) business days of the **Inquiry**, has the right to have the **Inquiry** processed as a **Complaint** at his/her option, including reduction of an oral **Inquiry** to writing by **HMO**, written acknowledgement and written resolution of the **Complaint**.

HMO maintains records of each **Inquiry** communicated by a **Member** or on his behalf, and each response thereto, for a minimum period of two (2) years. These records are subject to inspection by the Commissioner of Insurance and the Department of Public Health.

B. **Complaints.**

If an **Inquiry** is not resolved in three business days or 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.

C. **Appeals.**

The **Member** will receive written notice about the **Complaint** or adverse 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**.

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. All the rights of the **Member** also extend to the **Member's** authorized representative, which includes a **Member's** guardian, conservator, holder of a power of attorney, health care agent designated pursuant to the law, family member, or another person authorized by the **Member** in writing or by law with respect to a specific **Appeal** or external review, provided that if the **Member** is unable to designate a representative, where such designation would otherwise be required, a conservator, holder of a power of attorney, or family member in that order of priority may be the **Member's** representative or appoint another responsible party to serve as the **Member's** authorized representative. If the authorized representative is a health care provider, the **Member** must specify a named individual who will act on behalf of the authorized representative and a telephone number for that individual.

Requests for an **Appeal** must be made by telephone, in person, by mail, or by electronic means within 180 calendar days from the date of the notice. Oral **Appeals** made by the **Member**, or the authorized representative, shall be reduced to writing by **HMO** and a copy thereof forwarded to the **Member** by **HMO** within 48 hours of receipt, except where this time limit is waived or extended by mutual written agreement of the **Member** or the **Member's** authorized representative and **HMO**. A written acknowledgement of the receipt of an **Appeal** shall be sent to the **Member** or the **Member's** authorized representative, if any, within 15 business days of said receipt, except where an oral **Appeal** has been

reduced to writing by **HMO** or this time period is waived or extended by mutual written agreement of the **Member** or the **Member's** authorized representative and **HMO**.

A **Member** may contact Member Services at the toll-free telephone number on their ID card for assistance in resolving **Appeals**. A **Member** may also contact the **Office of Patient Protection** at their toll-free number 1-800-436-7757, facsimile (617-624-5046) or via the internet site (www.state.ma.us/dph/opp).

The **HMO** provides for two levels of **Appeal**. The described two-level **Appeal** process will be completed within 30 business days, regardless of the number of levels in the process. When an **Appeal** requires the review of medical records, the 30 business day period will not begin to run until the **Member**, or the **Member's** authorized representative, submits a signed authorization for release of medical records and treatment information. In the event the signed authorization is not provided by the **Member**, or the **Member's** authorized representative, if any, within 30 business days of the receipt of the **Appeal**, **HMO** may, in its discretion, issue a resolution of the **Appeal** without review of some or all of the medical records.

In at least one level of review of an **Appeal**, the **Appeal** shall be reviewed with the participation of an individual who is an actively practicing health care professional in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment that is the subject of the **Appeal**.

The **Member** must complete the two levels of **HMO** review before bringing a lawsuit against the **HMO**. Any second level of **Appeal** is strictly voluntary and not a prerequisite to filing an external appeal to the **Office of Patient Protection**. 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. The following chart summarizes some information about how the **Appeals** are handled for different types of claims.

HMO Timeframe for Responding to an Appeal

Please refer to Section C. for information regarding certain types of Claims that may be eligible for an expedited Appeal Process.

Type of Claim	Level One Appeal HMO Response Time from Receipt of Appeal	Level Two Appeal HMO Response Time from Receipt of Appeal
Urgent Care Claim. A claim for medical care or treatment where delay could seriously jeopardize the life or health of the **Member**, the ability of the **Member** to regain maximum function; or subject the **Member** to severe pain that cannot be adequately managed without the requested care or treatment.	Within 36 hours Review provided by **HMO** personnel not involved in making the **Complaint** or adverse determination.	Within 36 hours Review provided by **HMO Appeals** Committee.
Pre-Service Claim. A claim for a benefit that requires approval of the benefit in advance of obtaining medical care.	Within 15 calendar days Review provided by **HMO** personnel not involved in making the **Complaint** or adverse 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 business days Level I Review provided by **HMO** personnel not involved in making the **Complaint** or adverse determination. Level II Review provided by **HMO Appeals** Committee.	

The time limits stated above may be waived or extended by mutual written agreement of the **Member** or the **Member's** authorized representative, and the **HMO**. Any such agreement shall state the additional time limits, which shall not exceed 30 business days from the date of the agreement. If additional information is required and the **Member** does not agree to an extension, **HMO** shall make a decision based on the information available.

If **HMO** fails to reduce an oral **Appeal** to writing and forward a copy to the **Member** within 48 hours, fails to provide written acknowledgement of the receipt of an **Appeal** to the **Member** within 15 business days or fails to complete the two-level **Appeal** process within 30 business days, an **Appeal** shall be deemed resolved in favor of the **Member**. Time limits include any extensions made by mutual written agreement of the **Member**, or the **Member's** authorized representative, if any, and **HMO**.

A written notice stating the results of the **Appeal** of the Adverse Determination shall include a substantive clinical justification that is consistent with generally accepted principals of professional medical practice that shall at a minimum:

(a) identify the specific information upon which the **Complaint** or adverse determination was based;

(b) discuss the **Member's** presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria;

(c) specify alternative treatment options covered by **HMO**, if any;

(d) reference and include applicable clinical practice guidelines and review criteria; and

(e) notify the **Member** or the **Member's** authorized representative of the procedures for requesting external review, including the procedure to request an expedited external review.

If an **Appeal** is filed concerning the termination of ongoing coverage or treatment, the disputed coverage or treatment shall remain in effect at the **HMO's** expense through completion of the internal **Appeal** process, regardless of the original internal **Appeal** decision. Ongoing coverage or treatment include only that medical care that, at the time it was initiated, was authorized by **HMO** and does not include medical care that was terminated pursuant to a specific time or episode-related exclusion from the **Member's** contract for benefits.

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

C. **Expedited Appeal Review Procedures.**

1. In the event the **Member** is a **Hospital** inpatient, **Member** shall receive a written resolution of an expedited review, and the opportunity to request continuation of services, of the **Appeal** prior to **Hospital** discharge. If the expedited review results in an adverse benefit determination regarding the continuation of inpatient care, the written resolution must inform the **Member** or the **Member's** authorized representative of the opportunity to request an expedited external review.

2. In the event the **Appeal** is of an emergent or urgent nature where the **Physician** believes that denial of coverage for a **Medically Necessary** service would cause serious harm to the **Member**, an **HMO** Medical Director shall review the matter as soon as possible or within 48 hours, and communicate a decision to the **Member** by telephone.

3. Provisions for the automatic reversal of decisions denying coverage for services or durable medical equipment, pending the outcome of the **Appeal** process, within 48 hours or earlier for durable medical equipment at the option of a Physician responsible for treatment or proposed treatment of the covered patient of receipt of certification by said **Physician** that, in the **Physician's** opinion:

    1. the service or use of durable medical equipment at issue in an **Appeal** is **Medically Necessary**;

    2. a denial of coverage for such services or durable medical equipment would create a substantial risk of serious harm to the **Member**; and

    3. such risk of serious harm is so immediate that the provision of such services or durable medical equipment should not await the outcome of the normal **Appeal** process.

    Provisions that require that, in the event a **Physician** exercises the option of automatic reversal earlier than 48 hours for durable medical equipment, the **Physician** must further certify as to the specific immediate and severe harm that will result to the **Member** absent action within the 48 hour time period.

4. In the event the **Member** has a terminal illness, an expedited review of the **Appeal** will be completed within 5 days from the receipt of the **Appeal**.

    If the expedited review process affirms the denial of coverage to a **Member** with a terminal illness, **HMO** shall provide the **Member**, within five (5) business days of the decision:

    a. a statement setting forth the specific medical and scientific reasons for denying coverage;

    b. a description of alternative treatment, services or supplies covered by **HMO**, if any; and

    c. the procedure for the **Member** to request a conference.

    HMO shall schedule such conference within 10 days of receiving the request for a conference from a **Member**. At the conference the information provided to the **Member** pursuant to provisions (1) and (2) above shall be reviewed by the **Member** and a representative of the **HMO** who has authority to determine the disposition of the **Appeal**. **HMO** shall permit attendance at the conference of the **Member**, a designee of the **Member** or both, or, if the **Member** is a minor or incompetent, the parent, guardian or conservator of the **Member** as appropriate. The conference shall be held within 5 business days if the treating **Physician** determines, after consultation with the **HMO's** Medical Director or designee, and based on standard medical practice, that the effectiveness of either the proposed treatment, services or supplies or any

alternative treatment, services or supplies covered by **HMO**, would be materially reduced if not provided at the earliest possible date.

D. **External Review Process.**

A **Member**, who remains aggrieved by an adverse determination and has exhausted at least one level of **Appeal** from the formal **Appeal** process, may seek further review of the **Appeal** by a review panel established by the **Office of Patient Protection**. The request for an external review must be made within 45 days of receipt of the **HMO's Appeal** determination. For the purposes of this provision, an adverse determination is based upon a review of information provided by **HMO** to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other health care services, for failure to meet the requirements for coverage based on **Medical Necessity**, appropriateness of health care setting and level of care, or effectiveness.

A **Member** or the **Member's** authorized representative, if any, may request to have his or her request for review processed as an expedited external review.

1. Any request for an expedited external review shall contain a certification, in writing, from a **Physician**, that delay in the providing or continuation of health care services that are the subject of a final adverse determination, would pose a serious and immediate threat to the health of the **Member**.

2. Upon finding that a serious and immediate threat to the **Member** exists, the **Office of Patient Protection** shall qualify such request as eligible for an expedited external review.

3. A **Member** seeking a review shall pay a fee of $25.00, to the **Office of Patient Protection**, which shall accompany the request for a review. The fee may be waived by said office if it determines that the payment of the fee would result in an extreme financial hardship to the **Member**.

4. The remainder of the cost for an external review shall be borne by **HMO**. Upon completion of the external review, the **Office of Patient Protection** shall bill **HMO** the amount established pursuant to contract between the Department and the assigned external review agency minus the $25.00 fee, which is the **Member's** responsibility.

5. In connection with any request for an external review, **HMO** shall assure that the **Member**, and where applicable the **Member's** authorized representative, have access to any medical information and records relating to the insured, in the possession of **HMO** or under **HMO's** control.

6. Request for review submitted by the **Member** or the **Member's** authorized representative shall:

   (a) be on a form prescribed by the Department;

   (b) include the signature of the **Member** or the **Member's** authorized representative consenting to the release of medical information;

   (c) include a copy of the written final adverse determination issued by **HMO**; and

   (d) include the required $25 fee.

7. If the subject matter of the external review involves the termination of ongoing services, the **Member** may **Appeal** to the external review panel to seek the continuation of coverage for the terminated service during the period the review is pending. Any such request must be made before the end of the second business day following receipt of the final adverse determination. The review panel may order the continuation of coverage or treatment where it determines that

substantial harm to the **Member's** health may result absent such continuation or for such other good cause as the review panel shall determine. Any such continuation of coverage shall be at the **HMO's** expense regardless of the final external review determination.

8. The decision of the review panel shall be binding.

The **Office of Patient Protection**, established by the Department of Public Health, is responsible for the administration and enforcement of certain Massachusetts Managed Care requirements. A **Member** may obtain the necessary forms to seek an external review by calling the **Office of Patient Protection** at its toll-free telephone number (1-800-436-7757), facsimile (617-624-5046) or via the internet site (www.state.ma.us/dph/opp). A **Member** may also contact the **Office of Patient Protection** to obtain a report detailing, for the previous calendar year, the total number of:

a) a list of sources of independently published information assessing insureds' satisfaction and evaluating the quality of health care services offered by **HMO**;

b) the percentage of **Physicians** who voluntarily and involuntarily terminated participation contracts with the carrier during the previous calendar year for which such data has been compiled and the three most common reasons for voluntary and involuntary **Physician** disenrollment;

c) the percentage of premium revenue expended by the carrier for health care services provided to insureds' for the most recent year for which information is available; and

d) a report detailing, for the previous calendar year, the total number of:

1. filed **Appeals**, **Appeals** that were approved internally, **Appeals** that were denied internally, and **Appeals** that were withdrawn before resolution; and

2. external **Appeals** pursued after exhausting the internal **Appeals** process and the resolution of all such **Appeals**.

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**.

4. The following section entitled "Dispute Resolution" has been added to the **Certificate**:

DISPUTE RESOLUTION

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

Any Claim alleging wrongful acts or omissions of **Participating** or **non-participating Providers** shall not include **HMO**. A **Member** must exhaust all **Complaint**, **Appeal** and independent external review procedures prior to the commencement of an arbitration hereunder. No person may recover any damages arising out of or related to the failure to approve or provide any benefit or coverage beyond payment of or coverage for the benefit or coverage where (i) **HMO** has made available independent external review and (ii) **HMO** has followed the reviewer's decision. Punitive damages may not be recovered as part of a Claim under any circumstances. No **Interested Party** may participate in a representative capacity or as a member of any class in any proceeding arising out of or related to the **Group Agreement**. This agreement to arbitrate shall be specifically enforced even if a party to the arbitration is also a party to another proceeding with a third party arising out of the same matter.

AETNA HEALTH INC.
(MASSACHUSETTS)

HORMONE REPLACEMENT THERAPY AND CONTRACEPTIVES SERVICES AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

1. The **Injectable Medication Benefits** section of the **Certificate** is hereby deleted in its entirety and replaced with the following:

   - **Injectable Medication Benefits.**

     Injectable medications, including those medications intended to be self administered, hormone replacement therapy injections including, but not limited to, services for peri and post menopausal woman 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-approved 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 one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) and the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer reviewed journal.

2. The **Covered Benefits** section of the **Certificate** has been amended to include the following:

   - **Contraceptives Services.**

     Coverage is provided for Contraceptive Services which include consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of all contraceptive methods to prevent pregnancy, that have been approved by the United States Food and Drug Administration (FDA), are covered. The applicable **copayment** will apply as shown in the Schedule of Benefit.

AETNA HEALTH INC.
(MASSACHUSETTS)

MENTAL HEALTH BENEFITS AMENDMENT

Group Agreement Effective Date: January 1, 2013

The following definitions are hereby added to the Definitions section of the **Certificate** of Coverage**:**

Biologically-Based Mental Disorder. Coverage shall be provided for the medical treatment and diagnosis of certain Biologically-Based Mental Disorders (including Substance Abuse) under the same terms and conditions and which are no less extensive than coverage provided for any other type of health care for physical illness. The following Biologically-Based Mental Disorders shall be covered:

a. Schizophrenia;
b. Schizo-Affective Disorder;
c. Major Depressive Disorder;
d. Bipolar Disorder;
e. Paranoia and other Psychotic Disorders;
f. Obsessive-Compulsive Disorder;
g. Panic Disorder;
h. Delirium and Dementia;
i. Affective Disorders;
j. Eating Disorders;
k. Post Traumatic Stress Disorders;
l. Substance Abuse Disorders; and
m. Pervasive Development Disorder (Autism).

Treatment is generally provided by or under the direction of a physician or mental health professional such as a psychiatrist, a psychologist, a licensed independent clinical social worker, a licensed mental health counselor, or a licensed nurse mental health clinical specialist.

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

Any one of the following conditions is 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.
- Paranoia and other psychotic disorders.
- Delirium and dementia.
- Affective disorders.
- Eating disorders.
- Post traumatic stress disorders.
- Substance Abuse
- All other mental disorders not otherwise identified and which are described in the most recent edition of the diagnostic and statistical Manual of Mental Disorders (DSM).

Non-Biologically Based Mental Disorder. A mental disorder that is not defined as a **Biologically-Based Mental Illness** or disorder in this plan.

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

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of alcoholism, drug abuse, **mental disorders**, or **biologically-based mental disorders**.

Psychiatric Hospital. This is an institution that meets all of the following requirements.

- Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, drug abuse, **Mental Disorders**, or **Biologically-Based Mental Disorders**.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a **Hospital** in the area for, any other medical service that may be required.
- Is supervised full-time by a **Psychiatric Physician** who is responsible for patient care and is there regularly.
- Is staffed by **Psychiatric Physicians** involved in care and treatment.
- Has a **Psychiatric Physician** present during the whole treatment day.
- Provides, at all times, psychiatric social work and nursing services.
- Provides, at all times, **Skilled Nursing Services** by licensed nurses who are supervised by a full-time **R.N.**
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **Psychiatric Physician**.
- Makes charges.
- Meets licensing standards.

The Mental Health Benefits provision of the Covered Benefits section of the **Certificate** of Coverage is hereby deleted in its entirely and replaced with the following:

J. **Mental Health Benefits.**

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

Note: Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See the *Exclusions and Limitations* section of this **Certificate** for more information.

Treatment of a Biologically-Based Mental Disorder

Covered Benefits include charges made by a **Hospital**, **Psychiatric Hospital**, **Residential Treatment Facility** or by **Participating Behavioral Health Providers** for the treatment of **Biologically-Based Mental Disorders** (including substance abuse). Coverage shall be provided for **Biologically-Based Mental Disorders** under the same terms and conditions and which are no less extensive than coverage provided for any other type of health care for physical illness. This includes the same copayments, coinsurance, deductibles, and/or annual lifetime maximums.

Benefits are payable for the following:

- Inpatient – Inpatient services may be provided in a general **Hospital** licensed to provide such services, in a facility under the direction and supervision of the department of mental health, in a private mental **Hospital** licensed by the department of mental health, or in a substance abuse facility licensed by the department of public health;

- Intermediate services – includes charges for a range of non-inpatient services that provide more intensive and extensive treatment interventions when outpatient services alone are not sufficient to meet the **Member's** needs. Intermediate services include, but are not limited to, the following:

    - *Acute and other residential treatment* – Mental health services provided in a 24-hour setting, with clinical staff and appropriately trained professional and paraprofessional staff to insure safety for the **Member** while providing active treatment and reassessment.

    - *Clinically managed detoxification services* – 24 hour, seven days a week, clinically managed detoxification services in a licensed non-hospital setting that include 24 hour per day supervision, observation and support, and nursing care, seven days a week.

    - *Partial hospitalization* – Short-term day/evening mental health programming available five to seven days per week. These services consist of therapeutically intensive acute treatment within a therapeutic milieu and include daily psychiatric management.

    - *Intensive Outpatient Programs (IOP)* – Multimodal, inter-disciplinary, structured behavioral health treatment provided over the course of two to three hours per day for multiple days per week in an outpatient setting. Includes, but is not limited to, diagnosis, evaluation and treatment of mental health and substance abuse disorders.

    - *Day treatment* - Services based on a planned combination of diagnostic, treatment and rehabilitative approaches to a person with mental illness or substance abuse disorder who needs more active or intensive treatment. Day treatment programs encompass generally some portion of a day or week rather than a weekly visit to a mental health clinic, individual provider's office or hospital outpatient department. The **Member** does not need 24-hour hospitalization or partial hospitalization.

    - *Crisis stabilization* – Short-term psychiatric treatment in structured, community-based therapeutic environments. Community Crisis Stabilization provides continuous 24-hour observation and supervision for individuals who do not require Inpatient Services.

    - *In-home therapy services* – An intensive combination of diagnostic and treatment interventions delivered in the home and community to a youth and family designed to sustain the youth in his or her home and/or to prevent the youth's admission to an inpatient hospital, psychiatric residential treatment facility, or other psychiatric treatment setting.

    The following services are not considered intermediate services:

    - Programs in which the patient has a pre-defined duration of care without the health plan's ability to conduct concurrent determinations of continued medical necessity for the **Member**.

    - Programs that only provide meetings or activities that are not based on individualized treatment planning.

    - Programs that focus solely on improvement in interpersonal or other skills rather than treatment directed toward symptom reduction and functional recovery related to amelioration of specific psychiatric symptoms or syndromes.

    - Tuition-based programs that offer educational, vocational, recreational or personal development activities, such as a therapeutic school, camp or wilderness program. **HMO** must provide coverage for outpatient or intermediate services provided while the

individual is in the program, subject to the terms of this **Certificate** including any network requirements or co-payments/coinsurance provisions.

- Programs that provide primarily custodial care services.

- For outpatient treatment – provided in a licensed **Hospital**, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, a professional office, or home-based services, provided, however, services delivered in such offices or settings are rendered by a licensed mental health professional acting within the scope of their license.

- Rape Related Mental or Emotional Disorders - Coverage shall be provided for the diagnosis and treatment of rape related mental or emotional disorders if you are a victim of a rape or victim of an assault with intent to commit rape under the same terms and conditions and which are no less extensive that coverage provided for any other type of health care for physical illness.

- Children and Adolescents under the age of 19 - Benefits shall be covered under the same terms and conditions and which are not less extensive than coverage provided for an other health care for physical illness, for children and adolescents under the age of 19 for the diagnosis and treatment of **Non-Biologically-Based Mental**, behavioral or emotional disorders, as described in the most recent edition of the DSM, which substantially interfere with or substantially limit the functioning and social interactions of such a child or adolescent; provided, that said interference or limitation is documented by and the referral for said diagnosis and treatment is made by the **Primary Care Provider**, primary pediatrician or a licensed mental health professional of such a child or adolescent or is evidenced by conduct, including but not limited to:

  (1) an inability to attend school as a result of such a disorder;
  (2) the need to hospitalize the child or adolescent as a result of such a disorder;
  (3) a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others.

  HMO shall continue to provide such benefits to any adolescent who is engaged in an ongoing course of treatment beyond the adolescent's nineteenth birthday until said course of treatment is completed and while the benefit contract under which such benefits first became available remains in effect, or subject to a subsequent benefits contract which is in effect. Please note that if COBRA or state continuation is selected, then all plan benefits will be available. If COBRA or state continuation is not selected, any premiums paid by the Policyholder to continue the mental health benefits beyond age 19 will continue health benefits only and COBRA or state continuation eligibility will not be extended.

- Psychopharmacological Services/Neuropsychological Assessment Services - Coverage shall be provided for the diagnosis and treatment of psychopharmacological services/neuropsychological assessment services under the same term and conditions and which are no less extensive than coverage provided for any other type of health care for physical illness.

In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan prescribed and supervised by a **Behavioral Health Provider**.
- The plan includes follow-up treatment.

If a **Member** requires ongoing care from a **Participating Behavioral Health Provider**, the **Member** may receive a standing **Referral** to such **Participating Behavioral Health Provider**. The **Participating Behavioral Health Provider** agrees to a treatment plan for the **Member** and provides the **PCP** with all necessary clinical and administrative information on a regular basis. The health care services provided must be consistent with the terms of the **HMO Certificate**.

Treatment of a Non-Biologically-Based Mental Disorder

Covered Benefits include charges made by a **Hospital**, **Psychiatric Hospital**, **Residential Treatment Facility** or **Participating Behavioral Health Provider's** office for the treatment of **Non-Biologically-Based Mental Disorders.** Coverage will be provided for outpatient and inpatient treatment for the diagnosis and treatment of all other covered **Mental Disorders** subject to the maximum number of visits and days, if any shown on the *Schedule of Benefits*. In addition to meeting all other conditions for coverage, the treatment plan must include follow-up treatment.

Benefits are payable for the following:

- Inpatient – Inpatient services may be provided in a general **Hospital** licensed to provide such services, in a facility under the direction and supervision of the department of mental health, in a private mental **Hospital** licensed by the department of mental health, or in a substance abuse facility licensed by the department of public health;

- Intermediate services – includes charges for a range of non-inpatient services that provide more intensive and extensive treatment interventions when outpatient services alone are not sufficient to meet the **Member's** needs. Intermediate services include, but are not limited to, the following:

    - *Acute and other residential treatment* – Mental health services provided in a 24-hour setting, with clinical staff and appropriately trained professional and paraprofessional staff to insure safety for the **Member** while providing active treatment and reassessment.

    - *Clinically managed detoxification services* – 24 hour, seven days a week, clinically managed detoxification services in a licensed non-hospital setting that include 24 hour per day supervision, observation and support, and nursing care, seven days a week.

    - *Partial hospitalization* – Short-term day/evening mental health programming available five to seven days per week. These services consist of therapeutically intensive acute treatment within a therapeutic milieu and include daily psychiatric management.

    - *Intensive Outpatient Programs (IOP)* – Multimodal, inter-disciplinary, structured behavioral health treatment provided over the course of two to three hours per day for multiple days per week in an outpatient setting. Includes, but is not limited to, diagnosis, evaluation and treatment of mental health and substance abuse disorders.

    - *Day treatment* - Services based on a planned combination of diagnostic, treatment and rehabilitative approaches to a person with mental illness or substance abuse disorder who needs more active or intensive treatment. Day treatment programs encompass generally some portion of a day or week rather than a weekly visit to a mental health clinic, individual provider's office or hospital outpatient department. The **Member** does not need 24-hour hospitalization or partial hospitalization.

    - *Crisis stabilization* – Short-term psychiatric treatment in structured, community-based therapeutic environments. Community Crisis Stabilization provides continuous 24-hour observation and supervision for individuals who do not require Inpatient Services.

    - *In-home therapy services* – An intensive combination of diagnostic and treatment interventions delivered in the home and community to a youth and family designed to sustain the youth in his or her home and/or to prevent the youth's admission to an inpatient hospital, psychiatric residential treatment facility, or other psychiatric treatment setting.

The following services are not considered intermediate services:

- Programs in which the patient has a pre-defined duration of care without the health plan's ability to conduct concurrent determinations of continued medical necessity for the **Member**.

- Programs that only provide meetings or activities that are not based on individualized treatment planning.

- Programs that focus solely on improvement in interpersonal or other skills rather than treatment directed toward symptom reduction and functional recovery related to amelioration of specific psychiatric symptoms or syndromes.

- Tuition-based programs that offer educational, vocational, recreational or personal development activities, such as a therapeutic school, camp or wilderness program. **HMO** must provide coverage for outpatient or intermediate services provided while the individual is in the program, subject to the terms of this **HMO Certificate** including any network requirements or co-payments/coinsurance provisions.

- Programs that provide primarily custodial care services.

- For outpatient treatment – provided in a licensed **Hospital**, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, a professional office, or home-based services, provided, however, services delivered in such offices or settings are rendered by a licensed mental health professional acting within the scope of their license.

In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan prescribed and supervised by a **Behavioral Health Provider**.
- The plan includes follow-up treatment.

If a **Member** requires ongoing care from a **Participating Behavioral Health Provider**, the **Member** may receive a standing **Referral** to such **Participating Behavioral Health Provider**. The **Participating Behavioral Health Provider** agrees to a treatment plan and provides the primary care physician with all necessary clinical and administrative information on a regular basis. The health care services provided must be consistent with the terms of the **HMO Certificate**.

HMO may require consent to the disclosure of information regarding services for mental disorders only to the same or similar extent in which **HMO** requires consent for the disclosure of information for other medical conditions.

AETNA HEALTH INC.
(MASSACHUSETTS)

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 2 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 request that **HMO** conduct a grievance hearing, as described in the Grievance Procedure section of this **Certificate**, within 15 working days after receiving notice that **HMO** has or will terminate the **Member's** coverage as described in the Termination For Cause subsection of this **Certificate**, **HMO** will continue the **Member's** coverage in force until a final decision on the **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 requested a grievance hearing, 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** Grievance Procedure to register a **Complaint** against **HMO** The grievance process described in the preceding paragraph applies only to those terminations affected pursuant to the Termination for Cause subsection of the **Certificate**.

   No termination shall relieve the **Contract Holder** from any obligation incurred prior to the date of termination of this **Certificate**.

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

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

   HMO shall have no liability or responsibility under this **Certificate** for covered services provided on or after the date of termination of coverage.

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

CLAIM PROCEDURES

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

HMO will make a decision on the **Member's** claim.

HMO shall make an initial Utilization Review determination regarding a proposed admission, procedure or service claim within two (2) working days of obtaining all necessary information. Necessary information shall include the results of any face-to-face clinical evaluation or second opinion that may be required. In the case of a determination to approve a Utilization Review admission, procedure or service, **HMO** shall notify the **Provider** rendering the service by telephone within 24 hours, and shall provide written or electronic confirmation of the telephone notification to the **Member** and the **Provider** within two (2) working days thereafter.

HMO shall make a concurrent Utilization Review determination within one (1) working day of obtaining all necessary information. In the case of a determination to approve a concurrent claim, **HMO** shall notify the **Provider** rendering the service by telephone within one (1) working day, and shall provide written or electronic confirmation to the **Member** and the **Provider** within one (1) working day thereafter. The written or electronic notification shall include the number of extended days or the next review date, the new total number of days or services approved, and the date of admission or initiation of services.

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. "Adverse benefit determinations" is a determination based upon a review of information provided by **HMO** to deny, reduce, modify or terminate an admission, continued inpatient stay, or the availability of any other health care services, for failure to meet the requirements for coverage based on medically necessity, appropriateness of health care setting and level of care or effectiveness. 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.
- 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 involving Utilization Review

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 2 working days of obtaining all necessary information
Concurrent Care Claim Extension. A request to extend a course of treatment previously pre-authorized by **HMO**.	As soon as possible, but not later than 24 hours and within 1 working day of obtaining all necessary information
Concurrent Care Claim Reduction or Termination. Decision to reduce or terminate a course of treatment previously pre-authorized by **HMO**.	Within 24 hours via telephone to the provider, and within 1 working day for written notification to the member and provider.
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** that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under **Appeal**.

HMO shall give a **Provider** treating a Member an opportunity to seek reconsideration of a Utilization Review adverse determination from a clinical peer reviewer in any case involving an initial determination or a concurrent review determination. The reconsideration process shall occur within one (1) working day of the receipt of the request and shall be conducted between the **Provider** rendering the service and the clinical peer reviewer or a clinical peer designated by the clinical peer reviewer if the reviewer cannot be available within one (1) working day. If the reconsideration process does not reverse the Utilization Review adverse determination, the **Member**, or the **Provider** on behalf of the **Member**, may pursue the Appeal Process. The reconsideration process shall not be a prerequisite to the Appeal Process or an expedited **Appeal**.

Adverse Benefit Determinations Which Do Not Involve Utilization Review

HMO Timeframe for Notification of an Adverse Benefit Determination Based on Plan Contractual Limitations

Type of Claim	HMO Response Time from Receipt of Claim
Urgent Care Claim. A claim for medical care or treatment where delay could seriously jeopardize the life or health of the **Member,** the ability of the **Member** to regain maximum function; or subject the **Member** to severe pain that cannot be adequately managed without the requested care or treatment.	As soon as possible but not later than 72 hours
Proposed Admission, Procedure or Service. A claim for a benefit that requires pre-authorization of the benefit in advance of obtaining medical care.	Within 2 working days of obtaining all necessary information

Concurrent Care Claim Extension. A request to extend a course of treatment previously pre-authorized by **HMO**.	As soon as possible, but not later than 24 hours and within 1 working day of obtaining all necessary information
Concurrent Care Claim Reduction or Termination. Decision to reduce or terminate a course of treatment previously pre-authorized by **HMO**.	Within 24 hours via telephone to the **Provider**, and within 1 working day for written notification to the member and provider.
Post-Service Claim. A claim for a benefit that is not a Proposed Admission, Procedure or Service.	Within 30 calendar days

COMPLAINTS AND APPEALS

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

- **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.
- **External Review.** A review of an adverse benefit determination or a final adverse benefit determination by a review panel appropriate for a grievance that include qualified clinical decision-makers experienced in the determination of **medical necessity**, utilization management protocols and grievance resolution, and shall not have any financial relationship with **Aetna**.

A. **Inquiries.**

The **Inquiry** Process is a process prior to the **Appeal** process during which **HMO** may attempt to answer questions and/or resolve concerns communicated on behalf of the **Member** to the **Member's** satisfaction within three business days. This process shall not be used for review of an adverse determination, which must be reviewed through the **Appeal** process.

HMO will address any **Inquiry** as expeditiously as possible, and provide a call back within 24 hours. **Member** whose **Inquiry** has not been explained or resolved to the **Member's** satisfaction within three (3) business days of the **Inquiry**, has the right to have the **Inquiry** processed as a **Complaint** at his/her option, including reduction of an oral **Inquiry** to writing by **HMO**, written acknowledgement and written resolution of the **Complaint**.

HMO maintains records of each **Inquiry** communicated by a **Member** or on his behalf, and each response thereto, for a minimum period of two (2) years. These records are subject to inspection by the Commissioner of Insurance and the Department of Public Health.

B. **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.

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 about the **Complaint** or 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**.

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. All the rights of the **Member** also extend to the **Member's** authorized representative, which includes a **Member's** guardian, conservator, holder of a power of attorney, health care agent designated pursuant to the law, family member, or another person authorized by the **Member** in writing or by law with respect to a specific **Appeal** or external review, provided that if the **Member** is unable to designate a representative, where such designation would otherwise be required, a conservator, holder of a power of attorney, or family member in that order of priority may be the **Member's** representative or appoint another responsible party to serve as the **Member's** authorized representative. If the authorized representative is a health care provider, the **Member** must specify a named individual who will act on behalf of the authorized representative and a telephone number for that individual.

Requests for an **Appeal** must be made by telephone, in person, by mail, or by electronic means within 180 calendar days from the date of the notice. Oral **Appeals** made by the **Member,** or the authorized representative, shall be reduced to writing by **HMO** and a copy thereof forwarded to the **Member** by **HMO** within 48 hours of receipt, except where this time limit is waived or extended by mutual written agreement of the **Member** of the **Member's** authorized representative and **HMO**. A written acknowledgement of the receipt of an **Appeal** shall be sent to the **Member** or the **Member's** authorized representative, if any, within 15 business days of said receipt, except where an oral **Appeal** has been reduced to writing by **HMO** or this time period is waived or extended by mutual written agreement of the **Member** or the **Member's** authorized representative and **HMO**.

A **Member** may contact Member Services at the toll-free telephone number on their ID card for assistance in resolving **Appeals**. A **Member** may also contact the **Office of Patient Protection** at their toll-free number 1-800-436-7757, facsimilie (617-624-5046) or via the Internet site (www.state.ma.us/dph/opp).

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 levels of **Appeal.** The described two-level **Appeal** process will be completed within 30 business days, regardless of the number of levels in the process. When an **Appeal** requires the review of medical records, the 30 business day period will not begin to run until the **Member**, or the **Member's** authorized representative, submits a signed authorization for release of medical records and treatment information. In the event the signed authorization is not provided by the **Member**, or the **Member's** authorized representative, if any, within 30 business days of the receipt of the **Appeal**, **HMO** may, in its discretion, issue a resolution of the **Appeal** without review of some or all of the medical records.

In at least one level of review of an **Appeal**, the **Appeal** shall be reviewed with the participation of an individual who is an actively practicing health care professional in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment that is the subject of the **Appeal**.

Any second level of **Appeal** is strictly voluntary and not a prerequisite to filing an external appeal to the **Office of Patient Protection**. 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. 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

Please refer to Section C. for information regarding certain types of Claims that may be eligible for an expedited Appeal Process.

Type of Claim	Level One Appeal HMO Response Time from Receipt of Appeal	Level Two Appeal HMO Response Time from Receipt of Appeal
Urgent Care Claim. A claim for medical care or treatment where delay could seriously jeopardize the life or health of the **Member,** the ability of the **Member** to regain maximum function; or subject the **Member** to severe pain that cannot be adequately managed without the requested care or treatment.	Within 24 hours Review provided by **HMO** personnel not involved in making the **adverse benefit determination**.	Within 24 hours Review provided by **HMO** Appeals Committee.

Proposed Admission, Procedure or Service. A claim for a benefit that requires approval of the benefit in advance of obtaining medical care.	Within 15 calendar days Review provided by **HMO** personnel not involved in making the adverse benefit determination.	Within 15 calendar days Review provided by **HMO** Appeals Committee.
Concurrent Care Claim Extension. A request to extend or a decision to reduce a previously approved course of treatment.	Treated like an urgent care claim or a pre-service claim depending on the circumstances.	Treated like an urgent care claim or a pre-service claim depending on the circumstances.
Post-Service Claim. Any claim for a benefit that is not a pre-service claim.	Within 30 calendar days Review provided by **HMO** personnel not involved in making the adverse benefit determination.	Within 30 calendar days Review provided by **HMO** Appeals Committee.

The time limits stated above may be waived or extended by mutual written agreement of the **Member** or the **Member's,** authorized representative, and the **HMO**. Any such agreement shall state the additional time limits, which shall not exceed 30 business days from the date of the agreement. If additional information is required and the **Member** does not agree to an extension, **HMO** shall make a decision based on the information available.

If **HMO** fails to reduce an oral **Appeal** to writing and forward a copy to the **Member** within 48 hours, fails to provide written acknowledge of the receipt of an **Appeal** to the **Member** with 15 business days or fails to complete the two-level **Appeal** process within 30 business days, an **Appeal** shall be deemed resolved in favor of the **Member**. Time limits include any extensions made by mutual written agreement of the **Member**, or the **Member's** authorized representative, if any, and **HMO**.

A written notice stating the results of the **Appeal** of the Adverse Determination shall include a substantive clinical justification that is consistent with generally accepted principals of professional medical practice that shall at a minimum:

a. identify the specific information upon which the **Complaint** or adverse determination was based;

b. discuss the **Member's** presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria;

c. specify alternative treatment options covered by **HMO**, if any;

d. reference and include applicable clinical practice guidelines and review criteria; and

e. notify the **Member** of the **Member's** authorized representative of the procedures for requesting external review, including the procedure to request an expedited external review.

HMO will furnish **Member** with a copy of the form prescribed by the Department for filing the request for an external review.

If an **Appeal** is filed concerning the termination of ongoing coverage or treatment, the disputed coverage or treatment shall remain in effect at the **HMO'sAHIC's** expense through completion of the internal **Appeal** process, regardless of the original internal **Appeal** decision, provided the **Appeal** is filed on a timely basis, based on the course of treatment. Ongoing coverage or treatment include only that medical care that, at the time it was initiated, was authorized by **HMO** and does not include medical care that was terminated pursuant to a specific time or episode-related exclusion from the **Member's** contact for benefits.

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. **Expedited Appeal Review Procedures.**

1. In the event the **Member** is a **Hospital** inpatient, **Member** shall receive a written resolution of an expedited review, and the opportunity to request continuation of services, of the **Appeal** prior to **Hospital** discharge. If the expedited review results in an adverse benefit determination regarding the continuation of inpatient care, the written resolution must inform the **Member** or the **Member's** authorized representative of the opportunity to request an expedited external review and the opportunity to request continuation of services pursuant to 105 CMR 128.414. While **Member** is a **Hospital** inpatient, a **Participating Provider** or a representative from the **Hospital** may act as **Member's** representative without the need for a written authorization from **Member**.

2. In the event the **Appeal** is of an emergent or urgent nature where the **Physician** believes that denial of coverage for a **Medically Necessary** service would cause serious harm to the **Member**, a **HMO** Medical Director shall review the matter as soon as possible or within 48 hours, and communicate a decision to the **Member** by telephone, and also a written notification within 48 hours upon receipt of certificication from a physician.

    a. the service is **Medically Necessary**;

    b. a denial of coverage for such services would create a substantial risk of serious harm to the **Member**; and

    c. such risk of serious harm is so immediate that the provision of such services should not await the outcome of the normal **Appeal** process.

3. Within less than 48 hours of receipt of certification by the **Physician** who ordered any durable medical equipment that is subject to appeal, **HMO** will provide **Member** with a written resolution when such **Physician**:

    a. certifies that the use of the durable medical equipment is **Medically Necessary**.

    b. Certifies that a denial of coverage for such durable medical equipment would create a substantial risk of serious harm to the patient.

c. Certifies that such risk of such serious harm is so immediate that the provision of such durable medical equipment should not await the outcome of the normal appeals process;

d. Describes the specific, immediate and severe harm that will result to the patient absent action within 48 hours; and

e. Specifies a reasonable time period in which **HMO** must provide a response.

4. If the expedited review process set forth in 3 or 4 above results in an adverse determination, the written resolution will inform **Member**, or **Member's** representative of the opportunity to request an expedited external review, and if the review involves the termination of ongoing services, the opportunity to request continuation of services during the period the review is pending. Any such continuation shall be at **HMO** expense, regardless of the final external review determination.

5. In the event the **Member** has a terminal illness, a resolution of an expedited review of the **Appeal** will be provided to the member or the member's representative within 5 days from the receipt of the **Appeal**.

   If the expedited review process affirms the denial of coverage to a **Member** with a terminal illness, **HMO** shall provide the **Member**, within five (5) business days of the decision:

   a. a statement setting forth the specific medical and scientific reasons for denying coverage;

   b. a description of alternative treatment, services or supplies covered by **HMO**, if any; and

   c. the procedure for the **Member** to request a conference.

   HMO shall schedule such the conference within 10 days of receiving the request for a conference from a **Member**, at the conference the information provided to the **Member** pursuant to provisions (1) and (2) above shall be reviewed by the **Member** and a representative of the **HMO** who has authority to determine the disposition of the **Appeal**. **HMO** shall permit attendance at the conference of the **Member**, a designee of the **Member** or both, or, if the **Member** is a minor or incompetent, the parent, guardian or conservator of the **Member** as appropriate. The conference shall be held within 5 business days if the treating **Physician** determines, after consultation with the **HMO's** Medical Director or designee, and based on standard medical practice, that the effectiveness of either the proposed treatment, services or supplies or any alternative treatment, services or supplies covered by **HMO**, would be materially reduced if not provided at the earliest possible date.

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

A **Member,** who remains aggrieved by an adverse determination and has exhausted at least one level of **Appeal** from the formal **Appeal** process, may seek further review of the **Appeal** by filing a request in writing with the **Office of Patient Protection**. The request for an external review must be made within 45 days of receipt of the **HMO's Appeal** determination. For the purposes of this provision, an adverse determination is based upon a review of information provided by **HMO** to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other health care services, for failure to meet the requirements for coverage based on **Medical Necessity**, appropriateness of health care setting and level of care, or effectiveness.

A **Member** or the **Member's** authorized representative, if any, may request to have his or her request for review processed as an expedited external review.

1. Any request for an expedited external review shall contain a certification, in writing, from a **Physician**, that delay in the providing or continuation of health care services that are the subject of a final adverse determination, would pose a serious and immediate threat to the health of the **Member**.

2. Upon finding that a serious and immediate threat to the **Member** exists, the **Office of Patient Protection** shall qualify such request as eligible for an expedited external review.

3. A **Member** seeking a review shall pay a fee of $25.00, to the **Office of Patient Protection**, which shall accompany the request for a review. The fee may be waived by said office if it determines that the payment of the fee would result in an extreme financial hardship to the **Member**.

4. The remained of the cost for an external review shall be borne by **HMO**. Upon completion of the external review, the **Office of Patient Protection** shall bill **HMO** the amount established pursuant to contract between the Department and the assigned external review agency minus the $25.00 fee, which is the **Member's** responsibility.

5. In connection with any request for an external review, **HMO** shall assure that the **Member**, and where applicable the **Member's** authorized representative, have access to any medical information and records relating to the insured, in the possession of **HMO** or under **HMO's** control.

6. Request for review submitted by the **Member** or the **Member's** authorized representative shall:

    a. be on a form prescribed by the Department;

    b. include the signature of the **Member** or the **Member's** authorized representative consenting to the release of medical information;

    c. include a copy of the written final adverse determination issued by **HMO**; and

    d. include the required $25 fee.

7. If the subject matter of the external review involves the termination of ongoing services, the **Member** may **Appeal** to the external review panel to seek the continuation of coverage for the terminated service during the period the review is pending. Any such request must be made before the end of the second business day following receipt of the final adverse determination. The review panel may order the continuation of coverage or treatment where it determines that substantial harm to the **Member's** health may result absent such continuation or for such other good cause as the review panel shall determine. Any such continuation of coverage shall be at the **HMO's** expense regardless of the final external review determination.

8. The decision of the review panel shall be binding.

If the external review agency overturns **HMO** decision in whole or in part, **HMO** shall issue a written notice to **Member** within five (5) business days of receipt of the written decision from the external review agency. Such notice shall:

a. acknowledge the decision of the review agency;

b. advise **Member** of any additional procedures for obtaining the requested coverage of services;

c. advise **Member** of the date by which the payment will be mad or the authorization for services will be issued by **HMO**; and

d. advise **Member** of the name and phone number of the person within **HMO** who will assist **Member** with final resolution of the **Appeal**.

The **Office of Patient Protection**, established by the Department of Public Health, is responsible for the administration and enforcement of certain Massachusetts Managed Care requirements. A **Member** may obtain the necessary forms to seek an external review by calling the **Office of Patient Protection** at its toll-free telephone number (1-800-436-7757), facsimile (617-624-5046) or via the internet site (www.state.ma.us/dph/opp). A **Member** may also contact the **Office of Patient Protection** to obtain a report detailing, for the previous calendar year, the total number of:

a. a list of sources of independently published information assessing insureds' satisfaction and evaluating the quality of health care services offered by **HMO**;

b. the percentage of **Physicians** who voluntarily and involuntarily terminated participation contracts with the carrier during the previous calendar year for which such data has been compiled and the three most common reasons for voluntary and involuntary **Physician** disenrollment;

c. the percentage of premium revenue expended by the carrier for health care services provided to insureds' for the most recent year for which information is available; and

d. a report detailing, for the previous calendar year, the total number of:
   1. filed **Appeals**, **Appeals** that were approved internally, **Appeals** that were denied internally, and **Appeals** that were withdrawn before resolution; and

   2. external **Appeals** pursued after exhausting the internal **Appeals** process and the resolution of all such **Appeals**.

OPTIONAL DISPUTE RESOLUTION

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

Any Claim alleging wrongful acts or omissions of **Participating** or non-participating **Providers** shall not include **HMO**. A **Member** must exhaust all **Complaint**, **Appeal** and independent external review procedures prior to the commencement of an arbitration hereunder. No person may recover any damages

arising out of or related to the failure to approve or provide any benefit or coverage beyond payment of or coverage for the benefit or coverage where (i) **HMO** has made available independent external review and (ii) **HMO** has followed the reviewer's decision. Punitive damages may not be recovered as part of a Claim under any circumstances. No **Interested Party** may participate in a representative capacity or as a member of any class in any proceeding arising out of or related to the **Group Agreement**. This agreement to arbitrate shall be specifically enforced even if a party to the arbitration is also a party to another proceeding with a third party arising out of the same matter.

AETNA HEALTH INC.
(MASSACHUSETTS)

QUALIFIED MEDICAL CHILD SUPPORT ORDER AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

1. The following has been added to the Special Rules Which Apply to Children-Qualified Medical Child Support Order section under the "Enrollment**"** section located in the Eligibility and Enrollment section of the **Certificate**:

   "If the **Subscriber** fails to make an application to obtain coverage of a child, **HMO** shall enroll such child upon application by such child's other parent, by the division of medical assistance or upon receipt of a national medical support notice from the IVD agency."

AETNA HEALTH INC.
(MASSACHUSETTS)

DISCLOSURE NOTICE

* * * * * * * *

This disclosure notice is provided in accordance with the laws of the Commonwealth of Massachusetts. This disclosure notice is only a summary of certain provisions of the plan. The Aetna Health Inc. policy, agreement, or certificate of coverage should be consulted to determine governing contractual provisions. Members may contact the HMO at the telephone number shown on their I.D. Card.

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TERMINATION OF COVERAGE

A member's coverage may be cancelled, or its renewal refused, only in the following circumstances.

1. Failure by the member or other responsible party to make payments required under the contract;

2. Misrepresentation or fraud on the part of the member;

3. Commission of acts of physical or verbal abuse by the member which pose a threat to providers or other members of the **HMO** and which are unrelated to the physical or mental condition of the member;

4. Relocation of the member outside the service area of the **HMO**;

5. Non-renewal or cancellation of the group contract through which the member receives coverage; or

6. Failure by the member to meet the eligibility requirements of the contract.

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.

The **HMO** will make a decision on the **Member's** claim. For urgent care claims and pre-service claims, the **HMO** will send the **Member** written notification of the determination, whether adverse or not adverse.

HMO shall make an initial Utilization Review determination regarding a proposed admission, procedure or service claim within two (2) working days of obtaining all necessary information. Necessary information shall include the results of any face-to-face clinical evaluation or second opinion that may be required. In the case of a determination to approve a Utilization Review admission, procedure or service, **HMO** shall notify the **Provider** rendering the service by telephone within 24 hours, and shall provide written or electronic confirmation of the telephone notification to the **Member** and the **Provider** within two (2) working days thereafter.

HMO shall make a concurrent Utilization Review determination within one (1) working day of obtaining all necessary information. In the case of a determination to approve a concurrent claim, **HMO** shall notify the **Provider** rendering the service by telephone within one (1) working day, and shall provide written or electronic confirmation to the **Member** and the **Provider** within one (1) working day thereafter. The written or electronic notification shall include the number of extended days or the next review date, the new total number of days or services approved, and the date of admission or initiation of services.

For other types of claims, the **Member** may only receive notice if the **HMO** makes an adverse determination.

A **Member** may contact Member Services at the toll-free telephone number on their ID card to determine the status or outcome of Utilization Review decisions.

ADVERSE DETERMINATIONS

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

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

The written notice of an adverse determination shall include a substantive clinical justification that is consistent with generally accepted principals of professional medical practice and shall, at a minimum, also provide the following important information that will assist the **Member** in making an **Appeal** of the adverse determination, if the **Member** wishes to do so:

(a) identify the specific information upon which the adverse determination was based;

(b) discuss the **Member's** presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria;

(c) specify any alternative treatment options covered by **HMO**, if any;

(d) reference and include applicable clinical practice guidelines and review criteria; and

(e) a clear, concise and complete description of the **HMO**'s formal internal **Appeal** process and the procedures for obtaining external review, including the procedure to request an expedited external review.

Written notice of an adverse determination will be provided to the **Member** within the following time frames. Under certain circumstances, these time frames may be extended. Please see the Complaint and Appeals section of this **Certificate** for more information about **Appeals**.

UTILIZATION REVIEW

HMO Timeframe for Notification of a Utilization Review Adverse Determination

Type of Claim	HMO Response Time from Receipt of Claim
Urgent Care Claim. A claim for medical care or treatment where delay could seriously jeopardize the life or health of the **Member**, the ability of the **Member** to regain maximum function; or subject the **Member** to severe pain that cannot be adequately managed without the requested care or treatment.	Telephone the **Provider** within 24 hours. Send written or electronic confirmation of the telephone notification to the **Member** and the **Provider** within one working day thereafter
Proposed Admission, Procedure or Service. A claim for a benefit that requires pre-authorization of the benefit in advance of obtaining medical care.	Telephone the **Provider** within 24 hours. Send written or electronic confirmation of the telephone notification to the **Member** and the **Provider** within one working day thereafter.
Concurrent Care Claim Extension. A request to extend a course of treatment previously pre-authorized by **HMO**.	Telephone the **Provider** within 24 hours. Send written or electronic confirmation of the telephone notification to the **Member** and the **Provider** within one working day thereafter. The service shall be continued without liability to the **Member** until the **Member** has been notified of the determination.
Concurrent Care Claim Reduction or Termination. Decision to reduce or terminate a course of treatment previously pre-authorized by **HMO**.	Telephone the **Provider** within 24 hours. Send written or electronic confirmation of the telephone notification to the **Member** and the **Provider** within one working day thereafter. The service shall be continued without liability to the **Member** until the **Member** has been notified of the determination.
Post-Service Claim. A claim for a benefit that is not a proposed admission, procedure or service claim.	Within 30 calendar days

HMO shall give a **Provider** treating a **Member** an opportunity to seek reconsideration of a Utilization Review adverse determination from a clinical peer reviewer in any case involving an initial determination or a concurrent review determination. The reconsideration process shall occur within one (1) working day of the receipt of the request and shall be conducted between the **Provider** rendering the service and the clinical peer reviewer or a clinical peer designated by the clinical peer reviewer if the reviewer cannot be available within one (1) working day. If the reconsideration process does not reverse the Utilization Review adverse determination, the **Member**, or the

Provider on behalf of the **Member**, may pursue the **Appeal** Process. The reconsideration process shall not be a prerequisite to the **Appeal** Process or an expedited **Appeal**.

NON-UTILIZATION REVIEW

HMO Timeframe for Notification of a Non-Utilization Review Adverse Benefit Determination

Type of Claim	HMO Response Time from Receipt of Claim
Urgent Care Claim. A claim for medical care or treatment where delay could seriously jeopardize the life or health of the **Member**, the ability of the **Member** to regain maximum function; or subject the **Member** to severe pain that cannot be adequately managed without the requested care or treatment.	As soon as possible but not later than 72 hours
Pre-Service Claim. A claim for a benefit that requires pre-authorization of the benefit in advance of obtaining medical care.	Within 15 calendar days
Concurrent Care Claim Extension. A request to extend a course of treatment previously pre-authorized by **HMO**.	If an urgent care claim, as soon as possible but not later than 24 hours. Otherwise, within 15 calendar days
Concurrent Care Claim Reduction or Termination. Decision to reduce or terminate a course of treatment previously pre-authorized by **HMO**.	With enough advance notice to allow the **Member** to **Appeal**.
Post-Service Claim. A claim for a benefit that is not a pre-service claim.	Within 30 calendar days

COMPLAINTS AND APPEALS

HMO has procedures for **Members** to use if they are dissatisfied with a decision that **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 requests redress of an action, omission or policy of the **HMO**.
- **Appeal.** An **Appeal** is a request to the **HMO** to reconsider a **Complaint** or an adverse determination. The **Appeal** procedure for a **Complaint** or an adverse 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.

A. **Inquiries.**

The **Inquiry** Process is a process prior to the **Appeal** process during which **HMO** may attempt to answer questions and/or resolve concerns communicated on behalf of the **Member** to the **Member's** satisfaction within three business days. This process shall not be used for review of an adverse determination, which must be reviewed through the **Appeal** process.

HMO will address any **Inquiry** as expeditiously as possible, and provide a call back within 24 hours. A **Member** whose **Inquiry** has not been explained or resolved to the **Member's** satisfaction within three (3) business days of the **Inquiry**, has the right to have the **Inquiry** processed as a **Complaint** at his/her option, including reduction of an oral **Inquiry** to writing by **HMO**, written acknowledgement and written resolution of the **Complaint**.

HMO maintains records of each **Inquiry** communicated by a **Member** or on their behalf, and each response thereto, for a minimum period of two (2) years. These records are subject to inspection by the Commissioner of Insurance and the Department of Public Health.

B. **Complaints.**

If an **Inquiry** is not resolved in three business days or 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.

C. **Appeals.**

The **Member** will receive written notice about the **Complaint** or adverse 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**.

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. All the rights of the **Member** also extend to the **Member's** authorized representative, which includes a **Member's** guardian, conservator, holder of a power of attorney, health care agent designated pursuant to the law, family member, or another person authorized by the **Member** in writing or by law with respect to a specific **Appeal** or external review, provided that if the **Member** is unable to designate a representative, where such designation would otherwise be required, a conservator, holder of a power of attorney, or family member in that order of priority may be the **Member's** representative or appoint another responsible party to serve as the **Member's** authorized representative. If the authorized representative is a health care provider, the **Member** must specify a named individual who will act on behalf of the authorized representative and a telephone number for that individual.

Requests for an **Appeal** must be made by telephone, in person, by mail, or by electronic means within 180 calendar days from the date of the notice. Oral **Appeals** made by the **Member**, or the authorized representative, shall be reduced to writing by **HMO** and a copy thereof forwarded to the **Member** by **HMO** within 48 hours of receipt, except where this time limit is waived or extended by mutual written agreement of the **Member** or the **Member's** authorized representative and **HMO**. A written acknowledgement of the receipt of an **Appeal** shall be sent to the **Member** or the **Member's** authorized representative, if any, within 15 business days of said receipt, except where an oral **Appeal** has been reduced to writing by **HMO** or this time period is waived or extended by mutual written agreement of the **Member** or the **Member's** authorized representative and **HMO**.

A **Member** may contact Member Services at the toll-free telephone number on their ID card for assistance in resolving **Appeals**. A **Member** may also contact the **Office of Patient Protection** at their toll-free number 1-800-436-7757, facsimile (617-624-5046) or via the internet site (www.state.ma.us/dph/opp).

The **HMO** provides for two levels of **Appeal**. The described two-level **Appeal** process will be completed within 30 business days, regardless of the number of levels in the process. When an **Appeal** requires the review of medical records, the 30 business day period will not begin to run until the **Member**, or the **Member's** authorized representative, submits a signed authorization for release of medical records and treatment information. In the event the signed authorization is not provided by the **Member**, or the **Member's** authorized representative, if any, within 30 business days of the receipt of the **Appeal**, **HMO** may, in its discretion, issue a resolution of the **Appeal** without review of some or all of the medical records.

In at least one level of review of an **Appeal**, the **Appeal** shall be reviewed with the participation of an individual who is an actively practicing health care professional in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment that is the subject of the **Appeal**.

The **Member** must complete the two levels of **HMO** review before bringing a lawsuit against the **HMO**. Any second level of **Appeal** is strictly voluntary and not a prerequisite to filing an external appeal to the **Office of Patient Protection**. 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. The following chart summarizes some information about how the **Appeals** are handled for different types of claims.

HMO TIMEFRAME FOR RESPONDING TO AN APPEAL

Please refer to Section C. for information regarding certain types of Claims that may be eligible for an expedited Appeal Process.

Type of Claim	Level One Appeal HMO Response Time from Receipt of Appeal	Level Two Appeal HMO Response Time from Receipt of Appeal
Urgent Care Claim. A claim for medical care or treatment where delay could seriously jeopardize the life or health of the **Member**, the ability of the **Member** to regain maximum function; or subject the **Member** to severe pain that cannot be adequately managed without the requested care or treatment.	Within 36 hours Review provided by **HMO** personnel not involved in making the **Complaint** or adverse determination.	Within 36 hours Review provided by **HMO Appeals** Committee.
Pre-Service Claim. A claim for a benefit that requires approval of the benefit in advance of obtaining medical care.	Within 15 calendar days Review provided by **HMO** personnel not involved in making the **Complaint** or adverse 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 business days Level I Review provided by **HMO** personnel not involved in making the **Complaint** or adverse determination. Level II Review provided by **HMO Appeals** Committee.

The time limits stated above may be waived or extended by mutual written agreement of the **Member** or the **Member's** authorized representative, and the **HMO**. Any such agreement shall state the additional time limits, which shall not exceed 30 business days from the date of the agreement. If additional information is required and the **Member** does not agree to an extension, **HMO** shall make a decision based on the information available.

If **HMO** fails to reduce an oral **Appeal** to writing and forward a copy to the **Member** within 48 hours, fails to provide written acknowledgement of the receipt of an **Appeal** to the **Member** within 15 business days or fails to complete the two-level **Appeal** process within 30 business days, an **Appeal** shall be deemed resolved in favor of the **Member**. Time limits include any extensions made by mutual written agreement of the **Member**, or the **Member's** authorized representative, if any, and **HMO**.

A written notice stating the results of the **Appeal** of the Adverse Determination shall include a substantive clinical justification that is consistent with generally accepted principals of professional medical practice that shall at a minimum:

(a) identify the specific information upon which the **Complaint** or adverse determination was based;

(b) discuss the **Member's** presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria;

(c) specify alternative treatment options covered by **HMO**, if any;

(d) reference and include applicable clinical practice guidelines and review criteria; and

(e) notify the **Member** or the **Member's** authorized representative of the procedures for requesting external review, including the procedure to request an expedited external review.

If an **Appeal** is filed concerning the termination of ongoing coverage or treatment, the disputed coverage or treatment shall remain in effect at the **HMO's** expense through completion of the internal **Appeal** process, regardless of the original internal **Appeal** decision. Ongoing coverage or treatment include only that medical care that, at the time it was initiated, was authorized by **HMO** and does not include medical care that was terminated pursuant to a specific time or episode-related exclusion from the **Member's** contract for benefits.

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

C. **Expedited Appeal Review Procedures.**

1. In the event the **Member** is a **Hospital** inpatient, **Member** shall receive a written resolution of an expedited review, and the opportunity to request continuation of services, of the **Appeal** prior to **Hospital** discharge. If the expedited review results in an adverse benefit determination regarding

the continuation of inpatient care, the written resolution must inform the **Member** or the **Member's** authorized representative of the opportunity to request an expedited external review.

2. In the event the **Appeal** is of an emergent or urgent nature where the **Physician** believes that denial of coverage for a **Medically Necessary** service would cause serious harm to the **Member**, an **HMO** Medical Director shall review the matter as soon as possible or within 48 hours, and communicate a decision to the **Member** by telephone.

3. Provisions for the automatic reversal of decisions denying coverage for services or durable medical equipment, pending the outcome of the **Appeal** process, within 48 hours or earlier for durable medical equipment at the option of a **Physician** responsible for treatment or proposed treatment of the covered patient of receipt of certification by said **Physician** that, in the **Physician's** opinion:

    1. the service or use of durable medical equipment at issue in an **Appeal** is **Medically Necessary**;

    2. a denial of coverage for such services or durable medical equipment would create a substantial risk of serious harm to the **Member**; and

    3. such risk of serious harm is so immediate that the provision of such services or durable medical equipment should not await the outcome of the normal **Appeal** process.

    Provisions that require that, in the event a **Physician** exercises the option of automatic reversal earlier than 48 hours for durable medical equipment, the **Physician** must further certify as to the specific immediate and severe harm that will result to the **Member** absent action within the 48 hour time period.

4. In the event the **Member** has a terminal illness, an expedited review of the **Appeal** will be completed within 5 days from the receipt of the **Appeal**.

    If the expedited review process affirms the denial of coverage to a **Member** with a terminal illness, **HMO** shall provide the **Member**, within five (5) business days of the decision:

    a. a statement setting forth the specific medical and scientific reasons for denying coverage;

    b. a description of alternative treatment, services or supplies covered by **HMO**, if any; and

    c. the procedure for the **Member** to request a conference.

    HMO shall schedule such conference within 10 days of receiving the request for a conference from a **Member**. At the conference the information provided to the **Member** pursuant to provisions (1) and (2) above shall be reviewed by the **Member** and a representative of the **HMO** who has authority to determine the disposition of the **Appeal**. **HMO** shall permit attendance at the conference of the **Member**, a designee of the **Member** or both, or, if the **Member** is a minor or incompetent, the parent, guardian or conservator of the **Member** as appropriate. The conference shall be held within 5 business days if the treating **Physician** determines, after consultation with the **HMO's** Medical Director or designee, and based on standard medical practice, that the effectiveness of either the proposed treatment, services or supplies or any alternative treatment, services or supplies covered by **HMO**, would be materially reduced if not provided at the earliest possible date.

D. **External Review Process.**

A **Member,** who remains aggrieved by an adverse determination and has exhausted at least one level of **Appeal** from the formal **Appeal** process, may seek further review of the **Appeal** by a review panel established by the **Office of Patient Protection**. The request for an external review must be made within 45 days of receipt of the **HMO's Appeal** determination. For the purposes of this provision, an adverse determination is based upon a review of information provided by **HMO** to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other health care services, for failure to meet the requirements for coverage based on **Medical Necessity**, appropriateness of health care setting and level of care, or effectiveness.

A **Member** or the **Member's** authorized representative, if any, may request to have his or her request for review processed as an expedited external review.

1. Any request for an expedited external review shall contain a certification, in writing, from a **Physician**, that delay in the providing or continuation of health care services that are the subject of a final adverse determination, would pose a serious and immediate threat to the health of the **Member**.

2. Upon finding that a serious and immediate threat to the **Member** exists, the **Office of Patient Protection** shall qualify such request as eligible for an expedited external review.

3. A **Member** seeking a review shall pay a fee of $25.00, to the **Office of Patient Protection**, which shall accompany the request for a review. The fee may be waived by said office if it determines that the payment of the fee would result in an extreme financial hardship to the **Member**.

4. The remainder of the cost for an external review shall be borne by **HMO**. Upon completion of the external review, the **Office of Patient Protection** shall bill **HMO** the amount established pursuant to contract between the Department and the assigned external review agency minus the $25.00 fee, which is the **Member's** responsibility.

5. In connection with any request for an external review, **HMO** shall assure that the **Member**, and where applicable the **Member's** authorized representative, have access to any medical information and records relating to the insured, in the possession of **HMO** or under **HMO's** control.

6. Request for review submitted by the **Member** or the **Member's** authorized representative shall:

   (a) be on a form prescribed by the Department;

   (b) include the signature of the **Member** or the **Member's** authorized representative consenting to the release of medical information;

   (c) include a copy of the written final adverse determination issued by **HMO**; and

   (d) include the required $25 fee.

7. If the subject matter of the external review involves the termination of ongoing services, the **Member** may **Appeal** to the external review panel to seek the continuation of coverage for the terminated service during the period the review is pending. Any such request must be made before the end of the second business day following receipt of the final adverse determination. The review panel may order the continuation of coverage or treatment where it determines that substantial harm to the **Member's** health may result absent such continuation or for such other good cause as the review panel shall determine. Any such continuation of coverage shall be at the **HMO's** expense regardless of the final external review determination.

8. The decision of the review panel shall be binding.

The **Office of Patient Protection**, established by the Department of Public Health, is responsible for the administration and enforcement of certain Massachusetts Managed Care requirements. A **Member** may obtain the necessary forms to seek an external review by calling the **Office of Patient Protection** at its toll-free telephone number (1-800-436-7757), facsimile (617-624-5046) or via the internet site (www.state.ma.us/dph/opp). A **Member** may also contact the **Office of Patient Protection** to obtain a report detailing, for the previous calendar year, the total number of:

a) a list of sources of independently published information assessing insureds' satisfaction and evaluating the quality of health care services offered by **HMO**;

b) the percentage of **Physicians** who voluntarily and involuntarily terminated participation contracts with the carrier during the previous calendar year for which such data has been compiled and the three most common reasons for voluntary and involuntary **Physician** disenrollment;

c) the percentage of premium revenue expended by the carrier for health care services provided to insureds' for the most recent year for which information is available; and

d) a report detailing, for the previous calendar year, the total number of:

1. filed **Appeals**, **Appeals** that were approved internally, **Appeals** that were denied internally, and **Appeals** that were withdrawn before resolution; and

2. external **Appeals** pursued after exhausting the internal **Appeals** process and the resolution of all such **Appeals**.

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**.

1. The following section entitled "Dispute Resolution" has been added to the **Certificate**:

DISPUTE RESOLUTION

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

Any Claim alleging wrongful acts or omissions of **Participating** or **non-participating Providers** shall not include **HMO**. A **Member** must exhaust all **Complaint**, **Appeal** and independent external review procedures prior to the commencement of an arbitration hereunder. No person may recover any damages arising out of or related to the failure to approve or provide any benefit or coverage beyond payment of or coverage for the benefit or coverage

where (i) **HMO** has made available independent external review and (ii) **HMO** has followed the reviewer's decision. Punitive damages may not be recovered as part of a Claim under any circumstances. No **Interested Party** may participate in a representative capacity or as a member of any class in any proceeding arising out of or related to the **Group Agreement**. This agreement to arbitrate shall be specifically enforced even if a party to the arbitration is also a party to another proceeding with a third party arising out of the same matter.

QUALITY ASSURANCE PROGRAMS

Aetna Health Inc. has developed a comprehensive Quality Improvement Program that places strict attention on quality measurement and improvement and is designed to identify and respond to the health care concerns of our members. Some of our quality-focused initiatives include:

1. Routine monitoring of quality of service and care, including:

   - The performance of medical chart review audits in the office setting,
   - Medical director review of member utilization patterns to determine prevalence of acute and chronic conditions, and the need for focused disease management programs,
   - Comprehensive utilization management and case management programs,
   - Review of survey results which assess **Member** and provider satisfaction levels, and
   - Periodic analysis of provider availability and access.

2. Provider certification and recertification, as well as quality performance-based physician and facility contracting.

3. Adoption and use of practice guidelines, including preventive care recommendations.

4. Health promotion and wellness programs which seek to identify members who may be considered high-risk, and which offer incentives to members who participate and achieve predetermined goals in fitness, smoking-cessation, and weight-loss programs.

5. The use of an automated tracking system to monitor member complaints which help identify opportunities to improve service levels.

6. Programs to monitor and address potential underutilization, and denial or delay in providing needed services.

7. Measuring provider performance to improve the quality of care, assessing medical costs to improve the value of care, and delivering sophisticated and integrated data reporting products to customers.

8. The Quality Enhancement rewards primary care physicians for their scores on several measures intended to evaluate the quality of care and services the **Primary Care Physicians** provide to **Members**. **Primary Care Physician** offices can earn additional compensation for each **Member** each month based on the scores received on one or more of the following measures of the **Primary Care Physician's** office: member satisfaction, percentage of **Members** who visit the office at least annually, medical record reviews, the burden of illness of the members that have selected the primary care physician, management of chronic illnesses like asthma, diabetes and congestive heart failure; whether the **Physician** is accepting new patients, and participation in Aetna Health Inc.'s electronic claims and referral submission.

9. Annual evaluation of the Quality Improvement Program, including voluntary review and accreditation by the National Committee for Quality Assurance (NCQA), an independent, not-for-profit organization dedicated to assessing and reporting on the quality of care and service delivered by managed care organizations.

EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES

Experimental or Investigational Procedures means 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

    a) 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

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

CONTINUITY OF CARE

A. **HMO** shall notify a **Member** at least 30 days before the disenrollment of such member's primary care physician. A **Member** may continue to be covered for health services, consistent with the terms of the certificate, by such primary care physician for at least 30 days after the **Physician** is disenrolled, except for disenrollment for quality-related reasons or for fraud. A **Member** may change their PCP at any time by calling the **Member** Services toll-free telephone number listed on their identification card or by written or electronic submission of the **HMO** 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.

B. Coverage is provided for any female member who is in her second or third trimester of pregnancy and whose provider in connection with her pregnancy is involuntarily disenrolled, except for disenrollment for quality-related reasons or for fraud, to continue treatment with said provider, consistent with the terms of the **Certificate**, for the period up to and including the **Member's** first postpartum visit.

C. Coverage is provided for any member who is terminally ill and whose provider in connection with said illness is involuntarily disenrolled, except for disenrollment for quality-related reasons or for fraud, to continue treatment with said provider, consistent with the terms of the certificate, until the **Member's** death.

D. Coverage is provided for covered services for up to 30 days from the effective date of coverage to a new **Member** for services rendered by a non-**Participating Provider** if: (1) the **Member's** employer only offers the **Member** a choice of carriers in which said physician is not a **Participating Provider**, and (2) said **Physician** is providing the **Member** with an ongoing course of treatment or is the **Member's Primary Care Physician**. With respect to a **Member** in her second or third trimester of pregnancy, this provision shall apply to services rendered through the first postpartum visit. With respect to a **Member** with a terminal illness, this provision shall apply to services rendered until death.

E. **HMO** may condition coverage of continued treatment by a **Provider** under subsections A. through D., inclusive, upon the **Provider's** agreeing (1) to accept reimbursement from **HMO** at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to the **Member** in an amount that would exceed the cost sharing that could have been imposed if the provider had not been disenrolled; (2) to adhere to the quality assurance standards of **HMO** and to provide **HMO** with necessary medical information related to the care provided; and (3) to adhere to **HMO**'s policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing services pursuant to a treatment plan, if any, approved by **HMO**. Nothing in this subsection shall be construed to require the coverage of benefits that would not have been covered if the **Provider** involved remained a **Participating Provider**.

SPECIALIST PHYSICIAN

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 an **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**.

Coverage is provided for pediatric specialty care, including mental health care, by persons with recognized expertise in specialty pediatrics to **Members** requiring such services.

DIRECT ACCESS SPECIALIST BENEFITS

The following services are covered without a referral when rendered by a participating provider.

1. Routine Gynecological Examination(s). Routine gynecological visit(s) and pap smear(s), as well as medically necessary evaluations and resultant health care services for acute or emergency gynecological conditions. The maximum number of visits is provided in the certificate.

2. Open Access to Gynecologists. Benefits are provided to female members for services performed by a participating gynecologist for diagnosis and treatment of gynecological problems and maternity care.

HMO will not require higher copayments, coinsurance, deductibles or additional cost sharing arrangements for direct access services provided to a member in the absence of a referral from the **Primary Care Physician**.

PHYSICIAN PROFILING

Physician profiling information is available from the Massachusetts Board of Registration in Medicine for physicians licensed to practice in Massachusetts.

CLINICAL GUIDELINES AND UTILIZATION REVIEW CRITERIA

Aetna Health Inc. uses a wide range of commercially developed and nationally recognized guidelines and criteria, internally developed guidelines, reference tools, and published medical literature to assist in determining the appropriate level of coverage for services.

Local quality committees, composed of community practicing physicians and health plan staff review, update and adopt the review criteria at least annually and more frequently as necessary.

These criteria may include:

- Milliman and Robertson's Healthcare Management Guidelines and Length of Stay Guidelines
- InterQual's Severity of Illness/Intensity of Service (SI/IS),
- Western Region Experience of HCIA's Length of Stay (LOS) Guidelines
- Aetna Health Inc. developed Coverage Policy Bulletins
- Level of Care Assessment Tool (LOCAT)
- American Society of Addictive Medicine Patient Management Patient Placement Guidelines (ASAM)
- **HMO** Internal policies and procedures

INTERPRETER AND TRANSLATION SERVICES

A member may contact Member Services at the telephone number listed on their member identification card to receive information on interpreter and translation services related to administrative procedures. A TDD# is also available.

EMERGENCY CARE / URGENT CARE BENEFITS

A member has the option of calling the local pre-hospital emergency medical service system by dialing the emergency telephone access number 911, or its local equivalent, whenever the member is confronted with an emergency medical condition which in the judgement of a prudent layperson would require pre-hospital emergency services. A member shall not be discouraged from using the local pre-hospital emergency medical service system, the 911 telephone number, or the local equivalent.

Medical transportation is covered for an Emergency Medical Condition.

The member should notify their primary care physician as soon as possible after emergency or urgent care treatment. Notice given to **HMO**, designee or primary care physician by the attending emergency care physician shall satisfy this requirement.

VOLUNTARY AND INVOLUNTARY DISENROLLMENT RATE

The **HMO** voluntary disenrollment rate among insureds is 0% of members. The **HMO** involuntary disenrollment rate among insureds is 0% of members.

AETNA HEALTH INC.
(MASSACHUSETTS)

REHABILITATION AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

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

Rehabilitation Benefits.

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

1. Cardiac and Pulmonary Rehabilitation Benefits.

   a. Cardiac rehabilitation benefits are available as part of a **Member's** inpatient **Hospital** stay. A limited course of outpatient cardiac rehabilitation is covered when **Medically Necessary** following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction. In addition, outpatient cardiac rehabilitation meeting the standards of the Department of Public Health is also covered if initiated within 26 weeks after the diagnosis of the disease.

   b. Pulmonary rehabilitation benefits are available as part of a **Member's** inpatient **Hospital** stay. A limited course of outpatient pulmonary rehabilitation is covered when **Medically Necessary** for the treatment of reversible pulmonary disease states.

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

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

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

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

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

   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 (including Autism), Down Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.

AETNA HEALTH INC.
(MASSACHUSETTS)

ENROLLMENT ENDORSEMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

ELIGIBILITY AND ENROLLMENT

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

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

"Life Events" are limited to:

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

AETNA HEALTH INC.
(MASSACHUSETTS)

HOME HEALTH CARE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

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

- **Custodial Care.** Services and supplies that are primarily intended to help a **Member** meet their personal needs. Care can be **Custodial Care** even if it is prescribed by a **Physician**, delivered by trained medical personnel, or even if it involves artificial methods (or equipment) such as feeding tubes, monitors, or catheters. Examples of **Custodial Care** include, but are not limited to:

  1. Changing dressings and bandages, periodic turning and positioning in bed, administering oral medication, watching or protecting a **Member.**
  2. Care of a stable tracheostomy, including intermittent suctioning.
  3. Care of a stable colostomy/ileostomy.
  4. Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings.
  5. Care of a stable indwelling bladder catheter, including emptying/changing containers and clamping tubing.
  6. Respite care, adult (or child) day care, or convalescent care.
  7. Helping a **Member** perform an activity of daily living, such as: walking, grooming, bathing, dressing, getting in and out of bed, toileting, eating, or preparing food.
  8. Any services that an individual without medical or paramedical training can perform or be trained to perform.

- **Homebound Member.** A **Member** who is confined to their place of residence due to an illness or injury which makes leaving the home medically contraindicated or if the act of transport would be a serious risk to their life or health.

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

  1. A **Member** who does not often travel from home because of feebleness and/or insecurity brought on by advanced age (or otherwise).

  2. A wheelchair bound **Member** who could safely be transported via wheelchair accessible transport.

- **Skilled Nursing.** Services that require the medical training of and are provided by a licensed nursing professional and are not **Custodial Care**.

- **Skilled Nursing Facility.** An institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing **Skilled Nursing** care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. **Skilled Nursing Facility** does not include institutions which provide only minimal care, **Custodial Care** services, ambulatory or part-time care services, or institutions which primarily provide for the care and treatment of mental illness and substance abuse. The facility must qualify as a **Skilled Nursing Facility** under Medicare or as an institution accredited by the Joint Commission on

Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association, the Commission on the Accreditation of Rehabilitative Facilities, or as otherwise determined by the health insurer to meet the reasonable standards applied by any of the aforesaid authorities. Examples of **Skilled Nursing Facilities** include Rehabilitation Hospitals (all levels of care, e.g. acute) and portions of a **Hospital** designated for Skilled or Rehabilitation services.

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

Home Health Benefits.

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

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

Services of a home health aide are covered only when they are provided in conjunction with **Skilled Nursing** services and directly support the **Skilled Nursing.** Services must be provided during intermittent visits of 4 hours or less with a daily maximum of 3 visits.

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

Outpatient home health physical, speech, or occupational therapy is covered when the above home health care criteria are met. No maximum applies.

Additional services, including but not limited to nutritional consultation services and the use of **Durable Medical Equipment** and supplies, to the extent they are considered to be a **Medically Necessary** component of nursing or physical therapy.

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

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

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

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

AETNA HEALTH INC.

(MASSACHUSETTS)

ENDORSEMENT TO THE CERTIFICATE OF COVERAGE

Contract Holder Group Agreement Effective Date: January 1, 2013

Contract Holder: The Government of the District of Columbia

Contract Holder No.: 172614
(a contract issued in the Commonwealth of Massachusetts)

Effective Date: January 1, 2013

The following information is being provided to covered **Members** as required by the Massachusetts Managed Care Consumer Protections and Accreditation of Carriers Regulation 211 CMR 52.00.

The entire **Premiums** charged to the **Contract Holder** for the cost of health coverage under your plan of benefits are stated below. The amount that you contribute, if any, towards the cost of this health coverage is determined by the **Contract Holder**.

Summary of Monthly Billing Rates:

	Premium Rates
Aetna Open Access	
Single	$550.89
Parent & Child	$1,082.88
Parent & Children	$1,591.94
Couple	$1,082.88
Family	$1,591.94

The **Premium** rates shown above will become effective on January 1, 2013 and will remain in effect until December 31, 2013 in the absence of any material modifications made to the plan of benefits.

In accordance with the terms of the Group Agreement, the **Contract Holder** is expected to make premium payments to **HMO** on the monthly premium due date. A grace period will be allowed the **Contract Holder** for the payment of each premium in accordance with the Group Agreement. **HMO** has the right to terminate the Group Agreement as to all or any class of employees of the **Contract Holder** at any time after the end of the grace period if any premium, fee, charge, or rate for the coverage has not been paid. This right is subject to the terms of any laws or regulations.

AETNA HEALTH INC.
(MASSACHUSETTS)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Definitions section of the **Certificate** is hereby amended as follows:

The definition of "**Infertile** or **Infertility**" is hereby deleted and replaced with the following definition:

- **Infertile** or **Infertility.** The condition of a presumably healthy **Member** who is unable to conceive or produce conception during a period of 1 year.

The Direct Access to Gynecologists provision within the Direct Access Specialist Benefits under the Covered Benefits section of the **Certificate** is hereby deleted and replaced with the following:

- Direct Access to Gynecologists. Coverage is provided for initial and subsequent treatment to female **Members** for obstetric or gynecological services determined by such **Participating** obstetrician, gynecologist, certified nurse midwife or family practitioner to be **Medically Necessary** as a result of such examination, for diagnosis and treatment of gynecological problems and maternity care. See the Infertility Services Benefit section of this **Certificate** for a description of covered **Infertility** services.

The Comprehensive Infertility Services and Advanced Reproductive Technology (ART) Benefit provisions under the Covered Benefits section of the **Certificate** are hereby deleted.

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

- **Infertility Services Benefits.**

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

  2. **Comprehensive Infertility Services.**

     Member Eligibility. To be eligible for benefits, a **Member** must be covered under the **Certificate** as a **Subscriber** or a **Covered Dependent** and have a condition that is a demonstrated cause of **Infertility** as recognized by a **Participating** gynecologist or **Participating Infertility Specialist** and documented in the **Member's** medical records.

     If a **Member** meets the eligibility requirements above, the following Comprehensive **Infertility** Services are covered when provided by a **Participating Infertility Specialist** upon pre-authorization by **HMO**:

     a. ovulation induction; and

     b. intrauterine insemination.

3. **Advanced Reproductive Technology (ART) Services Benefits.**

Member Eligibility. To be eligible for benefits, a **Member** must exhaust **HMO's** Comprehensive **Infertility** Services benefits as described above; and

To obtain covered **ART Services** benefits, a **Member** must be:

a. referred by the **Member's PCP** or **Participating** gynecologist to the **Infertility Case Management** Unit, or the **Member** may directly contact **HMO's Infertility Case Management** Unit;

b. recommended for **ART** treatment by a **Participating ART Specialist** after an initial intake evaluation and consultation with the **Participating ART Specialist**;

c. determined by **HMO** to be eligible for participation in **HMO's Infertility** Program and pre-authorized by **HMO** for the **ART Services** benefit; and

d. issued pre-authorization for **ART Services** from **HMO's Infertility Case Management** Unit to a **Participating ART Specialist** with appropriate **Referrals**.

The following benefits are covered when all of the above conditions are met, subject to the Exclusions and Limitations section of the **Certificate**:

a. In Vitro Fertilization and Embryo Placement (IVF-EP);
Gamete Intra fallopian Transfer (GIFT);
Zygote Intrafallopian Transfer (ZIFT); or
cryopreserved embryo transfers;

b. Intracytoplasmic Sperm Injection for the treatment of male factor infertility (ICSI) or ovum microsurgery;

c. payment for charges associated with the care of the **Member** who is participating in a donor IVF-EP program, including fertilization and culture; and

d. charges associated with obtaining sperm, egg and/or inseminated egg procurement and processing and banking of sperm or inseminated eggs, for **ART** to the extent such costs are not covered by the donor's insurer, if any.

The **Infertility** and **Advanced Reproductive Technology Services** exclusion under the Exclusions and Limitations section of the **Certificate** is hereby deleted and replaced with the following exclusions:

- **Infertility and ART Services** including but not limited to:

1. **Infertility and ART Services** for female **Members** attempting to become pregnant who have been unable to conceive or produce conception during a period of least 1 year prior to enrolling in **HMO's Infertility** Program;

2. **Infertility and ART Services** for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal; unless that person can document that there has been a successful reversal of a sterilization procedure and has been unable to conceive or produce conception for a period of 1 year.

3. Reversal of sterilization surgery;

4. **Infertility and ART Services** for female **Members** with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;

5. The purchase of donor sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the **Member** or the gestational carrier. This exclusion does not apply to sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any;

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

7. Home ovulation prediction kits;

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

9. Any service provided without a **Referral** or pre-authorization from **HMO's Infertility Case Management** Unit;

10. **ART Services** that are not reasonably likely to result in success.

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

- Comprehensive **Infertility** Services are available only from the **Participating Infertility Specialist** for whom the **Member** has been issued a pre-authorization by **HMO's Infertility Case Management** Unit. Treatment received from a non-participating **Provider** or without a pre-authorization will not be covered and the **Member** will be responsible for payment of all services. Coverage for Comprehensive **Infertility** Services are only provided for referred care.

- **ART Services** are available only from the **Participating ART Specialists** for whom the **Member** has been issued a pre-authorization by **HMO's Infertility Case Management** Unit. Treatment received from a non-participating **Provider** or without a pre-authorization will not be covered and the **Member** will be responsible for payment of all services. Coverage for **ART Services** are only provided for referred care.

AETNA HEALTH INC.
(MASSACHUSETTS)

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 **Emergency Medical condition**s.

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, subject to written notification to the **Member** by the **PCP** and written acceptance by the **Member**.

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 prior written **Referral** issued by the **Member's PCP** or certified by **HMO**. This exclusion does not apply to an **Emergency Medical Condition,** in an **Urgent Care** situation, or when it is a direct access **Specialist** 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:

- Comprehensive **Infertility** and **Advanced Reproductive Technology (ART)** Services are not covered without pre-authorization from **HMO's Infertility** case management unit. A **Member** or their **Participating Physician** may contact the **Infertility** case management unit to apply for eligibility. A **Member** who is eligible will be subject to case management, have access to a select network of **Participating Providers** and will be required to utilize **Participating Providers** from this select network to receive **Covered Benefits**.

- 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.

AETNA HEALTH INC.
(MASSACHUSETTS)

COORDINATION OF BENEFITS

Contract Holder Group Agreement Effective Date: January 1, 2013

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

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

COORDINATION OF BENEFITS

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

Allowable Expense. A health care service or expense, including **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 **Hospital** room, the difference between the cost of a semi-private room in the **Hospital** and the private room (unless the **Member's** stay in the private **Hospital** room is **Medically Necessary** in terms of generally accepted medical practice, or one of the **Plans** routinely provides coverage of **Hospital** private rooms) is not an **Allowable Expense**.

2. If a **Member** is covered by 2 or more **Plans** that compute their benefit payments on the basis of **Reasonable Charge**, any amount in excess of the highest of the **Reasonable Charges** for a specific benefit is not an **Allowable Expense**.

3. If a **Member** is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable Expense**, unless the **Secondary Plan's** provider's contract prohibits any billing in excess of the provider's agreed upon rates.

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

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

Claim Determination Period(s). The calendar year.

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

Coordination of Benefits (COB). A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by 2 or more **Plans**. It avoids claims payment delays by establishing an order in

which **Plans** pay their claims and providing the authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a **Plan** when, by the rules established by this provision, it does not have to pay its benefits first.

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

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

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

1. Group, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
2. Other prepaid coverage under service plan contracts, or under group or individual practice;
3. Uninsured arrangements of group or group-type coverage;
4. Labor-management trusteed plans, labor organization plans, employer organization plans, or employee benefit organization plans;
5. Medical benefits coverage in 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 are 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 **Plans** meeting the definition of **Plan** under this section. In addition, this **Plan** will not pay more than it would have paid had it been primary.

Effect On Benefits Of This Certificate.

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

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

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

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

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

Effect of Medicare on COB.

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

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

1. Are covered under a program;

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

3. Have terminated coverage under a program; or

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

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

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

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

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

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

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

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

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

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

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

Multiple Coverage Under This Plan.

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

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

Right to Receive and Release Needed Information.

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits under this **Plan** and other **Plans**. **HMO** has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility of Payment.

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

Right of Recovery.

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

AETNA HEALTH INC.
MASSACHUSETTS

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement NonGroup Advantage Certificate of Coverage Effective Date: January 1, 2013

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

- **Self-injectable Drug(s)**. Prescription drugs that are intended to be self administered by injection to a specific part of the body to treat certain chronic medical conditions. An updated copy of the list of **Self-injectable Drugs** that are not **Covered Benefits** shall be available upon request by the **Member** or may be accessed at the **HMO** website, at www.aetna.com. The list is subject to change by **HMO** or an affiliate. The **Member** will be notified of any changes to this list within at least 60 days before the effective date of the modification.

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

- **Injectable Medications Benefits.**

  Injectable medications, except **Self-injectable Drugs** eligible for coverage under the Prescription Drug Rider, are a **Covered Benefit** when an oral alternative drug is not available, unless specifically excluded as described in the Exclusions and Limitations section of this **Certificate**. Medications must be prescribed by a **Provider** licensed to prescribe federal legend prescription drugs or medicines, and pre-authorized by **HMO**. If the drug therapy treatment is approved for self-administration, the **Member** is required to obtain covered medications at an **HMO Participating** pharmacy designated to fill injectable prescriptions.

  Injectable drugs or medication used for the treatment of cancer or HIV are covered when the off-label use of the drug has not been approved by the FDA for that indication, provided that such drug is recognized for treatment of such indication in 1 of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) and the safety and effectiveness of use for this indication has been adequately demonstrated by at least 1 study published in a nationally recognized peer reviewed journal.

AETNA HEALTH INC.
(MASSACHUSETTS)

Contract Holder Group Agreement Effective Date: January 1, 2013

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

The **Special Enrollment Period** and **Late Enrollment** provisions under the Eligibility and Enrollment section are deleted and replaced with the following:

6. Special Enrollment Period.

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

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

An eligible individual or an eligible dependent may be enrolled during a special enrollment period, if requirements a, b, c and d are met:

a. the eligible individual or the eligible dependent was covered under another group health plan or other health insurance coverage when initially eligible for coverage under **HMO**;

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

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

i. the other group health coverage is COBRA continuation coverage under another plan, and the COBRA continuation coverage under that other plan has since been exhausted; or

ii. the other coverage is a group health plan or other health insurance coverage, and the other coverage has been terminated as a result of loss of eligibility for the coverage or employer contributions towards the other coverage have been terminated.

Loss of eligibility includes the following:

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

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

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

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

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

Special Enrollment Period When a New Eligible Dependent is Acquired:

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

The special enrollment period is a period of 31days, 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**.

7. Late Enrollment.

Eligible individuals and their dependents may also be enrolled at any other time upon submission of complete enrollment information and payment of **Premium** to **HMO**. Coverage shall not become effective until confirmed, in writing, by **HMO**. The **Effective Date of Coverage** for a late enrollee will be no more than 12 months from the date of the application for coverage.

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

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

AETNA HEALTH INC.
(MASSACHUSETTS)

RESIDENTIAL TREATMENT FACILITY
CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

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

Residential Treatment Facility – (Mental Disorders)

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

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

Residential Treatment Facility – (Alcoholism and Drug Abuse)

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

- On-site licensed **Behavioral Health Provider** 24 hours per day/7 days a week
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a **Physician.**
- Has access to necessary medical services 24 hours per day/7 days a week.
- If the member requires alcohol or drug detoxification services, must have the availability of on-site medical treatment 24 hours per day/7days a week, which must be actively supervised by an attending **Physician**.

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

AETNA HEALTH INC.
(MASSACHUSETTS)

SUBROGATION AND WORKERS COMPENSATION AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

The **Subrogation and Right of Recovery** provision in the **Certificate** is hereby deleted and replaced with the following:

SUBROGATION AND RIGHT OF REIMBURSEMENT

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 subrogation. When this Plan provides health care benefits for expenses incurred due to Third Party injuries, **HMO** shall be subrogated to the **Member's** rights of recovery against any party to the extent of the full cost of all benefits provided by this Plan. **HMO** may proceed against any party with or without the **Member's** consent.

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. **HMO's** right of reimbursement is cumulative with and not exclusive of **HMO's** subrogation right and **HMO** may choose to exercise either or both rights of recovery. 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 subrogation and reimbursement under this **Certificate**;

C. Give **HMO** a first-priority lien on any recovery, settlement or judgment or other source of compensation which may be had from any party to the extent of the full cost of all benefits associated with 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 (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement, and regardless of whether such payment will result in a recovery to the **Member** which is insufficient to make the **Member** whole or to compensate the **Member** in part or in whole for the damages sustained), 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. No court costs or attorney fees may be deducted from **HMO's** recovery, and **HMO** is not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by the **Member** to pursue the **Member's** claim or lawsuit against any Responsible Party without the prior express written consent of **HMO.** In the event the **Member** or the **Member's** representative fails to cooperate with **HMO**, the **Member** shall be responsible for all benefits provided by this Plan in addition to costs and attorney's fees incurred by **HMO** in obtaining repayment.

RECOVERY RIGHTS RELATED TO WORKER'S COMPENSATION

If benefits are provided by **HMO** for illness or injuries to a **Member** and **HMO** determines the **Member** received Worker's Compensation benefits for the same incident that resulted in the illness or injuries, **HMO** has the right to recover as described under the Subrogation and Right of Reimbursement provision. "Worker's Compensation benefits" includes benefits paid in connection with a Worker's Compensation claim, whether paid by an employer directly, a worker's compensation insurance carrier, or any fund designed to provide compensation for worker's compensation claims. **HMO** will exercise its Recovery Rights against the **Member**.

The Recovery Rights will be applied even though:

a) The Worker's 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 Worker's Compensation benefits due to medical or health care is not agreed upon or defined by the **Member** or the Worker's Compensation carrier; or

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

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

AETNA HEALTH INC.
(MASSACHUSETTS)

DISCOUNT PROGRAMS CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

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

Q. **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.

AETNA HEALTH INC.
(MASSACHUSETTS)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

HMO. Aetna Health Inc., a Pennsylvania corporation licensed by the Massachusetts Division of Insurance as a Health Maintenance Organization.

AETNA HEALTH INC.
(MASSACHUSETTS)

ENTERAL FORMULA COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

10. Enteral formulas for home use when the **Primary Care Physician** issues a written order indicating the medical necessity of the formula for the treatment of malabsorption caused by Chron's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids. Coverage for inherited diseases of amino acids and organic acids shall include food products modified to be low protein in an amount not less than $5,000 per calendar year per **Member**, subject to applicable copayment.

AETNA HEALTH INC.
(MASSACHUSETTS)

PRIMARY CARE PHYSICIAN (PCP) AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

The Definition of **"Primary Care Physician (PCP)"** is hereby deleted and replaced with the following definition:

- **Primary Care Physician (PCP).** A **Participating Physician** or **Participating** Nurse Practitioner, 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.

AETNA HEALTH INC.
(MASSACHUSETTS)

HIPAA/CHIPRA SPECIAL ENROLLMENT AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

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

6. Special Enrollment Period.

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

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

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

a. the eligible individual or the eligible dependent was covered under another group health plan or other health insurance coverage when initially eligible for coverage under **HMO**;

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

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

d. the eligible individual or eligible dependent loses coverage under the other group health plan or other health insurance coverage for one of the following reasons:

i. the other group health coverage is COBRA continuation coverage under another plan, and the COBRA continuation coverage under that other plan has since been exhausted;

ii. the other coverage is a group health plan or other health insurance coverage, and the other coverage has been terminated as a result of loss of eligibility for the coverage or employer contributions towards the other coverage have been terminated; or

iii. the other health insurance coverage is Medicaid or an S-Chip plan and the eligible individual or eligible dependent no longer qualifies for such coverage.

Loss of eligibility includes the following:

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

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

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

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

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

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

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

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

Special Enrollment Period When a New Eligible Dependent is Acquired:

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

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

- In the case of marriage, the first day of the first calendar month following the date the completed request for enrollment is received.

- In the case of a dependent's birth, adoption or placement for adoption, the date of such birth, adoption or placement for adoption.

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

AETNA HEALTH INC.
(MASSACHUSETTS)

WELL CHILD CARE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

Section A.5, **Primary Care Physician Benefits,** found in the **Covered Benefits** section of the **Certificate** of Coverage is hereby deleted and replaced with the following:

5. Periodic health evaluations to include:

   a. well child care from birth including physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and development screening and assessment six times during the child's first year after birth, three times during the next year, annually until age six. Services shall also include hereditary and metabolic screening at birth, appropriate immunizations, and tuberculin tests, hematocrit, hemoglobin or other appropriate blood tests and urinalysis as recommended by a **Physician.**

   b. For children age six and older, 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;

   c. newborn hearing screening test to be performed before the newborn infant is discharged from the **Hospital** or birthing center;

   d. routine physical examinations;

   e. 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;

   f. routine hearing screenings;

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

   h. routine vision screenings.

AETNA HEALTH INSURANCE COMPANY
(MASSACHUSETTS)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

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

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

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

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

AETNA HEALTH INC.
(MASSACHUSETTS)

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 Health** (inpatient and outpatient);
- **Substance Abuse** (inpatient and outpatient);
- Outpatient Prescription Drug Rider benefits;
- Outpatient **Surgery** (when performed at a **Hospital** Outpatient Facility or at a facility other than a **Hospital** Outpatient Facility, including **Physician's** office visit surgery when performed by a **PCP** or **Specialist**);
- **Primary Care Physician (PCP)** and **Specialist Physician** Office Visits (including **E-visits**);
- Prosthetic Devices;
- **Skilled Nursing Facility**;
- Short Term Outpatient Rehabilitation Therapies (cognitive, occupational, physical and speech);
- **Transplants** (facility and non-facility);
- **Urgent Care**; and
- **Walk-in Clinic** visits.

THE ABOVE ESSENTIAL SERVICES MAY NOT BE **COVERED BENEFITS** UNDER THE **MEMBER'S 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.
(MASSACHUSETTS)

COMPASSIONATE CARE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

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

   - **Hospice Care**. A program of care that is provided by a **Hospital**, **Skilled Nursing Facility**, hospice, or a duly licensed Hospice Care agency, and is approved by **HMO**, and is focused on a palliative rather than curative treatment for **Members** who have a medical condition and a prognosis of less than 12 months to live.

AETNA HEALTH INC.
(MASSACHUSETTS)

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 six months; and
ix. demonstrates financial interdependence by submission of proof of three or more of the following:

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

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

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

AETNA HEALTH INC.
(MASSACHUSETTS)

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.

AETNA HEALTH INC.
MASSACHUSETTS

MORBID OBESITY SURGICAL TREATMENT RIDER

Contract Holder Group Agreement Effective Date: January 1, 2013

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

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

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

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

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

- **Morbid Obesity Surgical Benefits**

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

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

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

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

- Surgical operations, procedures or treatment of obesity, except when specifically approved by **HMO**.

- Weight reduction programs, or dietary supplements.

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

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

The Continuation and Conversion section of the **Certificate** is hereby amended to add the following provision:
The conversion privilege, if any, does not apply to the Morbid Obesity Surgical Treatment Rider.

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

MORBID OBESITY SURGICAL TREATMENT BENEFITS

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

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

AETNA HEALTH INC.
(MASSACHUSETTS)

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 Retail** or **Mail Order Pharmacy** designated by **HMO.** Except in an emergency or **Urgent Care** situation, or when the **Member** is traveling outside the **HMO Service Area**, prescriptions must be filled at a **Participating Retail** or **Mail Order Pharmacy**. Coverage of prescription drugs may, in **HMO's** sole discretion, be subject to the **Precertification Program**, the **Step Therapy Program** or other **HMO** requirements or limitations.

C. FDA approved prescription drugs and those for the treatment of cancer or for the treatment of HIV/AIDS 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.
  6. Urine glucose strips.
  7. Ketone strips.
  8. Insulin Pens.
  9. Oral medications.

- **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.
  7. All other contraceptive drugs and devices to prevent pregnancy which have been approved by the United States Food and Drug Administration (FDA).

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 Limitation section of the **Certificate** is amended to include the following exclusions and limitations:

A. **Exclusions**.

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

1. Any drug which does not, by federal or state law, require a prescription order (i.e., an over-the-counter (OTC) drug) or for which an equivalent over-the-counter product in strength, is available even when a prescription is written, unless otherwise covered by **HMO**.
2. Any drug determined not to be **Medically Necessary** for the treatment of disease or injury unless otherwise covered under this rider.
3. Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by **HMO**. This exclusion does not apply to the administration of the off label use of drugs for the treatment of cancer.
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 except 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 **Certificate**.

13. Medical supplies, devices and equipment and non-medical supplies or substances regardless of their intended use.
14. Test agents and devices except 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. Prescription orders filled prior to the effective date or after the termination date of the coverage provided by this rider.
18. Replacement for lost or stolen prescriptions.
19. Performance, athletic performance or lifestyle enhancement drugs and supplies.
20. 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.
21. 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.
22. Medication packaged in unit dose form. (Except those products approved for payment by **HMO)**.
23. Prophylactic drugs for travel.
24. Drugs recently approved by the FDA, but which have not yet been reviewed by the Aetna Health Inc. Pharmacy Management Department and Therapeutics Committee.
25. Drugs for the convenience of **Members** or for preventive purposes.
26. 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.
27. Oral and implantable contraceptives and contraceptive devices.
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; Claim Procedures/Complaints and Appeals/Dispute Resolution section of the **Certificate**.

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

4. **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 **Deductible Amount**, if any, or for any drug for which no charge is made to the recipient.

5. The Continuation and Conversion section, if any, of the **Certificate** 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.
(MASSACHUSETTS)

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.
(MASSACHUSETTS)

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: 760
Contract Holder Service Areas: NE01

BENEFITS

Benefit	Maximums
Maximum Out-of-Pocket Limit **Does not apply to Prescription Drug Benefits.**	
Individual Limit	**$3,500 per calendar year**
Family Limit	**$8,750 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.	
Member must demonstrate the Copayment amounts that have been paid during the year.	

OUTPATIENT BENEFITS

Benefit	Copayment
Primary Care Physician Services, Including but not limited to:	
Adult Physical Examination including Immunizations	**$0 per visit**
Visits are subject to the following visit maximum:	
Adults 18-65 years old: 1 visit per 12-month period	
Adults over 65 years old: 1 visit per 12-month period	
Well Child Physical Examination including Immunizations	**$0 per visit**
Office Hours Visits	**$10 per visit**
After-Office Hours and Home Visits	**$15 per visit**
Specialist Physician Services, including but not limited to:	
Office Visits (non-surgical)	**$20 per visit**

Office Visits for:	
Treatment of all other conditions	**$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**
Cardiac Rehabilitation	**$20 per visit**
Outpatient Speech, Hearing and Language Disorders	**$20 per visit**
Outpatient Physical and Occupational Therapy **20 combined Physical and Occupational Therapy visits per calendar year** **Limitations will not apply when services are Medically Necessary and provided in conjunction with a physician-approved home health services plan. Speech Therapy would not be subject to any limits other than for Medical Necessity.**	**$20 per visit**
Outpatient Facility Visits	**$20 per visit**
Diagnostic X-Ray Testing	**$0 per visit**
Complex Imaging Services, including, but not limited to: Magnetic Resonance Imaging (MRI); Computerized Axial Tomography (CAT); and Positron Emission Tomography (PET)	**$0 per visit**
Mammography (Diagnostic)	**$0 per visit**
Diagnostic Laboratory Testing, including but not limited to human leukocyte antigen testing	**$0 per visit**
Cytologic Testing	**$0 per visit**
Outpatient Emergency Services **Hospital Emergency Room, Urgent Care Facility, or Outpatient Department**	**$50 per visit**
Ambulance	**$0 per trip**
Outpatient Mental Disorders and Outpatient Substance Abuse (Detoxification and Rehabilitation) Visits	**$10 per visit**
Intensive Outpatient Programs, including all Medically Necessary Intermediate Care Services	**$10 per visit**
Outpatient Surgery	**$50 per visit**
Outpatient Home Health Visits **1 visit equals a period of 4 hours or less.**	**$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 and Substance Abuse (Detoxification and Rehabilitation)	
During a Hospital Confinement	**$100 per admission**
During a Residential Treatment Facility Confinement	**$100 per admission (waived if a Member is transferred from a Hospital to a Residential Treatment Facility)**
Maternity	**$100 per admission**
Skilled Nursing Facility	
Maximum of 60 days per 12-month period	**$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 Benefits	
Transplant Facility Expense Services	
Inpatient Care	**$100 per admission**

ADDITIONAL BENEFITS

Benefit	**Copayment**
Clinical Trials (to treat cancer)	**This benefit is subject to the applicable Copayment contained in this schedule for the type of service performed.**
Diabetes-related Services and Supplies	**This benefit is subject to the applicable Copayment contained in this schedule for the type of service performed.**
Early Intervention Services	**This benefit is subject to the applicable Copayment contained in this schedule for the type of service performed.**
Infertility Treatment	**This benefit is subject to the applicable Copayment contained in this schedule for the type of service performed.**
Low Protein Food Products for Inherited Amino Acid and Organic Acid Disease	**$20 per visit**

Non Prescription Enteral Formulas	**$20 per visit**
Hearing Screening for Newborns	**This benefit is subject to the applicable Copayment contained in this schedule for the type of service performed.**
Hormone Replacement Therapy Injections for peri- and post-menopausal women	**This benefit is subject to the applicable Copayment contained in this schedule for the type of service performed.**
Contraceptive Services	**This benefit is subject to the applicable Copayment contained in this schedule for the type of service performed.**
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) except for artificial limb devices to replace, in whole or in part, an arm or a leg (and their repair)	**$0 per item**
DME Maximum Benefit	**Unlimited per Member per calendar year**
This maximum does not apply to DME provided as part of a covered physician-approved Home Health services plan.	
Prosthetics, including but not limited to Scalp Hair Prostheses and artificial devices to replace, in whole or in part, an arm or a leg (and their repairs)*	
***No dollar maximum of any kind applies to prosthetic devices (and repairs).**	
Scalp Hair Prosthesis for Cancer or Leukemia	**$350 per calendar year**
Other prosthetics	**$0 per item**
Medically Necessary Hypodermic Syringes and Needles	**$0**

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 child of the Subscriber as described in the Eligibility and Enrollment section of the Certificate who is:

- **chiefly dependent upon the Subscriber for support and maintenance; or**
- **incapable of self-support due to mental or physical incapacity.**

The child will continue to be eligible until the earlier of: (a) the child's attainment of age 26; or (b) the date two (2) years after the end of the calendar year in which such persons last qualify as a dependent under 26 U.S.C. 106, whichever occurs first.

Any child of divorced parents who meets the expanded definition of dependent in connection with one parent is treated as a dependent of both parents.

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.