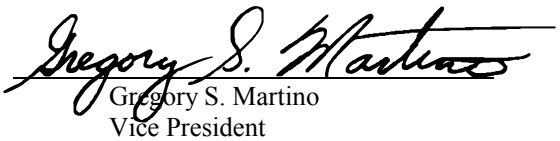
AETNA HEALTH INC.
(NEW YORK)
GROUP AGREEMENT COVER SHEET

Contract Holder:	Government of the District of Columbia
Contract Holder Number:	172614 038
HMO Referred Benefit Level:	CHARTER 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 New York.
Notice Address for **HMO**:	HMO Contracts WP42 151 Farmington Avenue Hartford, CT 06156-3061

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: Government of the District of Columbia
Contract Holder Number: 172614
Contract Holder Locations: 038
Contract Holder Group Agreement Effective Date: January 1, 2013

AETNA HEALTH INC.
(NEW YORK)

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 **Fee.** In addition to the **Premium**, **We** may charge the following fee:

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

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

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

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

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

3.5 **Changes in Premium.** **We** may also adjust the **Premium** rates and/or the manner of calculating **Premiums** effective as of any **Premium Due Date** upon 31 days' prior written notice to **Contract Holder**. **Premium** rates are rates approved by the New York Department of Insurance.

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 31 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**, and the eligibility requirements used to determine membership in 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 **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:

- Upon 30 days' written 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**;
- Upon 30 days' written 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; (iii) fails to provide the certification

required by Section 5.4 within a reasonable period of time specified by **Us**; or (iv) changes its eligibility or participation requirements without **Our** consent;

- Upon 90 days' written notice to **Contract Holder** and **Members** if **We** cease to offer the product to which the **Group Agreement** relates;

- Upon 180 days' written notice to **Contract Holder** and **Members** 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.

6.3 **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.

6.4 **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, except that **We** will notify the **Subscribers** in cases where **We** cease to offer coverage in the market or cease to offer coverage of a specific product in the market in accordance with state law. 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** may be changed upon approval by the New York Superintendent of Insurance, and 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
- Upon **Renewal**, by **Us** upon 30 days' written notice to **Contract Holder**.

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

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

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

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

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

- No statement made by **Contract Holder** or any **Member** shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing.

- No statement made by **Contract Holder** shall be the basis for voiding this **Group Agreement** after it has been in force for two years from its effective date.

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

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

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

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

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

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

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

only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

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

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

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

Workers' Compensation coverage is not a prerequisite for coverage under this plan.

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.
(NEW YORK)

GROUP AGREEMENT AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

Item 5.1 in Section 5 Responsibilities of the Contract Holder in the HMO Group Agreement is hereby deleted and replaced with the following:

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

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

- Maintain a reasonably complete record of such information (in electronic or hard copy format, including evidence of coverage elections, evidence of eligibility, changes to such elections and terminations) for at least seven years, and to make such information available to **Us** upon request.

- Obtain from all Subscribers a "Disclosure of Healthcare Information" authorization in the form currently being used by **Us** in the enrollment process (or such other form as **We** may reasonably approve).

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

- until stopped by the **Contract Holder**;

- if **Subscriber** has stopped working due to temporary lay off or leave of absence, not beyond the end of the policy month after the policy month in which the absence started; and

- if **Subscriber** stopped working due to disability, not beyond the end of the 30th policy month after the month in which the absence started.

AETNA HEALTH INC.
(NEW YORK)

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 New York.

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

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

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

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

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

Important

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

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

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HMO PROCEDURE

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

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

B. **The Primary Care Physician.**

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

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

In certain situations where a **Member** requires ongoing care from a **Specialist**, the **Member** may receive a standing **Referral** to such **Specialist**. Please refer to the Covered Benefits section of this **Certificate** for details.

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

C. **Availability of Providers.**

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

D. **Changing a PCP.**

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

E. **Ongoing Reviews.**

HMO conducts ongoing reviews of those services and supplies which are recommended or provided by **Health Professionals** to determine whether such services and supplies are **Covered Benefits** under this **Certificate**. If **HMO** determines that the recommended services and supplies are not **Covered Benefits**, the **Member** will be notified. If a **Member** wishes to **Appeal** such determination, the **Member** may then

contact **HMO** to seek a review of the determination. Please refer to the Claim Procedure/Complaints and Appeals section of this **Certificate**.

F. **Pre-authorization.**

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

METHOD OF PAYMENT

Maximum Out-of-Pocket Limit.

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

Benefit Limitations.

HMO will provide coverage to **Members** up to the Maximum Benefit for all Services and Supplies set forth on the Schedule of Benefits.

Calculations; Determination of Benefits.

A **Member's** financial responsibility for the costs of services will be calculated on the basis of when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of stays that occur in more than 1 **calendar year**. It is solely within the discretion of **HMO** to determine when benefits are covered 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) who meets the eligibility requirements described in this **Certificate** and on the Schedule of Benefits.

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

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

B. **Enrollment.**

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

1. Newly Eligible Individuals and Eligible Dependents.

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

2. Open Enrollment Period.

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

3. Enrollment of Newly Eligible Dependents.

   a. Newborn Children.

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

      The coverage for newly born, adopted children, and children placed for adoption consists of coverage of injury and sickness, including the necessary care and treatment of congenital defects and birth abnormalities, and within the limits of this **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-sustaining employment due to mental illness, developmental disability, mental retardation, or physical handicap. The incapacity must have commenced prior to the age the dependent would have lost eligibility. In order to continue coverage for a handicapped child, the **Subscriber** must provide evidence of the child's incapacity and dependency to **HMO** within 31 days of the date the child's coverage would otherwise terminate. Proof of continued incapacity, including a medical examination, must be submitted to **HMO** as requested, but not more frequently than annually beginning after the 2 year period following the child's attainment of the age specified on the Schedule of Benefits. This eligibility provision will no longer apply on the date the dependent's incapacity ends.

5. Notification of Change in Status.

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

An eligible individual and any eligible dependents may be enrolled during a special enrollment period. A special enrollment period occurs when:

a. an eligible individual or an eligible dependent is 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, employer contributions towards the other coverage have been terminated, or the other plan or contract terminated.

Loss of eligibility includes a loss of coverage as a result of legal separation, divorce, annulment, 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 the **HMO** Certificate of Coverage; 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 any late enrollment or preexisting condition provision described in this **Certificate**.

C. **Effective Date of Coverage.**

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

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

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

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** and obtained from **Participating Providers** within the **HMO** network. For the purpose of coverage, **HMO** may determine whether any benefit provided under the **Certificate** is **Medically Necessary**, and **HMO** has the option to only authorize coverage for a **Covered Benefit** performed by a particular **Provider**. Preventive care, as described below, will be considered **Medically Necessary**.

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

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

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

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

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

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

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

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

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

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

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

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

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

A. **Primary Care Physician Benefits.**

1. Office visits during office hours.

2. Home visits.

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

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

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

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

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

4. **Hospital** visits.

5. Periodic health evaluations to include:

   a. well child care for **Covered Dependents** from birth through the attainment of 19 years of age:

      i. an initial hospital check-up and well child visits scheduled in accordance with the prevailing clinical standards of a national association of pediatric physicians;
      ii. well child visits including a medical history, a complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests ordered at the time of the visit; and
      iii. necessary immunizations as recommended by the American Academy of Pediatrics and Department of Health and in accordance with the minimum benefits mandated by the State of New York.

   b. routine physical examinations;

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

   d. routine hearing screenings;

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

   f. routine vision screenings.

6. Injections, including allergy desensitization injections.

7. Casts and dressings.

8. Health Education Counseling and Information.

9. Diabetic Equipment, Supplies and Education. The following equipment, supplies and education services for the treatment of diabetic conditions are covered when ordered by the **Member's PCP " or other licensed health professional"** and obtained through a **Participating Provider**:

   a. Blood glucose monitors and blood glucose monitors for the legally blind;

   b. Control solutions used in blood glucose monitors;

   c. Data management systems;

   d. Test strips for glucose monitors and visual reading and urine test strips;

   e. Insulin;

   f. Injection aids;

   g. Cartridges for the visually impaired;

   h. Syringes, insulin pumps and appurtenances thereto;

i. Insulin infusion devices;

j. Oral agents for controlling blood sugar;

k. Glucagon for injection to increase blood glucose concentration;

l. Lancets and automatic lancing devices;

m. Urine testing products for glucose and ketones;

n. Alcohol swabs;

o. Disposable insulin cartridges and pen cartridges;

p. All insulin preparations;

q. Insulin pumps and equipment for the use of the pump including batteries;

r. Insulin infusion devices;

s. Such other equipment and related supplies required by the commissioner of the department of health; and

t. Coverage for diabetes self-management education, including information on proper diets.

Such coverage for self-management education and education relating to diet shall be limited to visits **Medically Necessary** upon the diagnosis of diabetes, where a **Physician** diagnoses a significant change in the patient's symptoms or conditions which necessitate changes in a patient's self-management, or where reeducation or refresher education is necessary. Coverage for self-management education and education relating to diet shall also include home visits when **Medically Necessary**.

10. Nutritional Formula.

Coverage shall also include nutritional supplements (formulas) as **Medically Necessary** for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria as administered under the direction of a **Physician**. Coverage shall include enteral formulas for home use when prescribed by a **Provider** licensed to prescribe federal legend prescription drugs or medicines. The written order shall state that the enteral formula is clearly **Medically Necessary** and has been proven effective as a disease-specific treatment regimen for **Members** who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death. Specific diseases for which enteral formulas have been proven effective shall include, but are not limited to, inherited diseases of amino-acid or organic acid metabolism, Crohn's disease, gastroesophageal reflux with failure to thrive, disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction, and multiple, severe food allergies which if left untreated will cause malnourishment, chronic physical disability, mental retardation or death. Enteral formulas which are **Medically Necessary** and taken under written order from a **Physician** for the treatment of specific diseases shall be distinguished from nutritional supplements taken electively. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low protein or which contain modified protein which are **Medically Necessary**, and coverage for modified solid food products shall not exceed $2500.00 dollars per calendar year.

B. **Diagnostic Services Benefits.**

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

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

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

   a. Mammography screening:

      - age 35 through 39, inclusive, one single baseline mammogram;

      - age 40 and older, one routine mammogram every year; or

      - at any age for a **Member** having a prior history of breast cancer or who has a first degree relative (e.g., mother or sister) with a prior history of breast cancer.

      - when **Medically Necessary**.

   b. Bone Density testing is covered for qualified **Members** for the purpose of early detection of osteoporosis.

      Bone mineral density measurements or tests, drugs and devices shall include those covered under the criteria of the federal Medicare program as well as those in accordance with the criteria of the National Institutes of Health, including, as consistent with such criteria, dual-energy x-ray absorptiometry.

      Bone mineral density measurements or tests, drugs and devices shall be covered for **Members** meeting the criteria for coverage, consistent with the criteria under the federal Medicare program or the criteria of the National Institutes of Health; provided that, to the extent consistent with such criteria, **Members** qualifying for coverage shall, at a minimum, include individuals:

         1. previously diagnosed as having osteoporosis or having a family history of osteoporosis;

         2. symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis;

         3. on a prescribed drug regimen posing a significant risk of osteoporosis; or

         4. with lifestyle factors to such a degree as posing a significant risk of osteoporosis; or

         5. of such age, gender or other physiological characteristics which pose a significant risk for osteoporosis.

3. Prostate cancer screening benefits are provided as follows:

   a. male **Members** of any age having a prior history of prostate cancer standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test; and

   b. male **Members** age 50 or over who are asymptomatic, an annual standard diagnostic examination including, but not limited to, a digital standard rectal examination and a prostate specific antigen test; and

c. male **Members** age 40 and over with a family history of prostate cancer or other prostate cancer risk factors an annual standard diagnostic examination including, but not limited to, a digital standard rectal examination and a prostate specific antigen test.

4. Newborn Screening Tests

Coverage is provided for the following newborn screenings: phenylketonuria, branched-chain ketonuria, homocystinuria, galactosemia, homozygous sickle cell disease, hypothyroidism, biotinidase deficiency and human immunodeficiency virus (HIV) exposure and virus, cystic fibrosis (CF), congenital adrenal (CAH), and medium-chain acyl-CoA dehydrogenase deficiency (MCADD).

C. **Specialist Physician Benefits.**

Covered Benefits include outpatient and inpatient services.

If a **Member** requires ongoing care from a **Specialist**, the **Member** may receive a standing **Referral** to such **Specialist**. If **PCP** in consultation with 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**.

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

D. **Direct Access Specialist Benefits.**

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

- Routine Gynecological Examination(s). Routine gynecological visit(s) and Pap smear(s). The maximum number of visits, if any, is listed on the Schedule of Benefits.

- Open Access Gynecological Care. Benefits are provided to female **Members** for services performed by a **Participating Provider** for diagnosis and treatment of gynecological problems. See the Infertility Services section of this **Certificate** for a description of **Infertility** benefits.

- Routine Eye Examinations, including refraction, as follows:

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

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

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

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

E. **Pre-Admission Testing.**

Preadmission testing performed in **Hospital** facilities prior to scheduled surgery. A **Member** who uses the out-patient facilities of a **Hospital** shall be entitled to benefits for tests ordered by a **Physician** which are

performed as a planned preliminary to admission of the patient as an in-patient for surgery in the same **Hospital**, provided that:

1) tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed;

2) reservations for a **Hospital** bed and for an operating room shall have been made prior to the performance of the tests;

3) surgery actually takes place within seven days of such pre-surgical tests; and

4) the **Member** is physically present at the hospital for tests.

F. **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 or of the time of the mother's request, whichever is later. 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.

Such maternity care shall include the services of a certified nurse-midwife, under qualified medical direction affiliated or practicing in conjunction with a licensed facility, or a **Physician**. Maternity care coverage shall also include, but is not limited to, parent education, assistance, and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments.

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

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

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

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

H. **Transplants Benefits.**

Transplants which are non-experimental or non-investigational are a **Covered Benefit**. Covered transplants must be ordered by the **Member's PCP** and **Participating Specialist Physician** and pre-authorized by **HMO**'s Medical Director. The transplant must be performed at **Hospitals** specifically approved and designated by **HMO** to perform these procedures. A transplant is non-experimental and non-investigational hereunder when **HMO** has determined, in its sole discretion, that the **Medical Community** has generally accepted the procedure as appropriate treatment for the specific condition of the **Member**. Coverage for a transplant where a **Member** is the recipient includes coverage for the medical and surgical expenses of a live donor, to the extent these services are not covered by another plan or program.

I. **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**.

J. **Substance Abuse Benefits.**

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

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

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

   Coverage is also included for family members, and includes visits for remediation of the adverse effects on the physical and mental health of family members which result from a close relationship with the **Member** receiving or in need of treatment for **Substance Abuse** or addiction. Such visits are for counseling and education. For purposes of this section, a visit includes comprehensive visits, day visits, or clinic visits. Visits do not include socialization visits. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.

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

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

K. **Mental Health Benefits.**

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

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

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

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

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

L. **Emergency Care/Urgent Care Benefits.**

1. Emergency Care:

   A **Member** is covered for **Emergency Services**, without prior approval, provided the service is a **Covered Benefit**, and **HMO**'s review determines that a **Medical Emergency** existed at the time medical attention was sought by the **Member**.

   A **Medical Emergency** is the existence of a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of such person or others in serious jeopardy; or (ii) serious impairment to such person's bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

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

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

been required had similar benefits been provided during office hours and upon prior **Referral** to a **Participating Provider**.

Medical transportation is covered during a **Medical Emergency**. Coverage will be provided for pre-hospital emergency medical services when such services are provided by an ambulance service. Pre-hospital emergency medical services are the prompt evaluation and treatment of an emergency medical condition, and/or non-air-borne transportation of the patient to a **Hospital.** Pre-hospital emergency services and non-air-borne emergency transportation reimbursement will be based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect that the lack of immediate medical transportation could result in (i) placing the health of such person or others in serious jeopardy; or (ii) serious impairment to such person's bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

2. **Urgent Care:**

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

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

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

M. **Outpatient Rehabilitation Benefits.**

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

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

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

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

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

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

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

N. **Home Health Benefits.**

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

1. Part-time or intermittent home nursing care or skilled nursing services for a **Homebound Member**. Treatment must be provided by or supervised by a registered nurse.

2. Part-time or intermittent services of a home health aide. These services are covered only when the purpose of the treatment is **Skilled Care** consists primarily of caring for the patient.

3. Medical social services, drugs and medications prescribed by a **Physician**, and laboratory services by or on behalf of a certified home health agency to the extent such items would have been covered or provided if the **Member** had been hospitalized or confined in a **Skilled Nursing Facility**. Treatment must be provided by or supervised by a qualified medical **Physician** or social worker, along with other **Home Health Services**. The **PCP** must certify that such services are necessary for the treatment of the **Member's** medical condition.

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

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

O. **Hospice Benefits.**

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

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**.

P. **Access to End of Life Care.**

Coverage may be provided to **Members** diagnosed with advanced cancer (with no hope of reversal of primary disease and fewer than sixty (60) days to live) as certified by the **Member's** attending **Physician** for acute care services at a **Participating** acute care facility specializing in the treatment of terminally ill patients, if the **Member's** attending **Physician**, in consultation with the medical director of the facility determines that the **Member's** care would appropriately be provided by the facility.

If the **HMO** disagrees with the admission of or provision or continuation of care for the **Member** by the facility, the **HMO** shall initiate an expedited external appeal, provided further, that until such decision is rendered, the admission of or provision or continuation of the care by the facility shall not be denied by **HMO** and **HMO** shall provide coverage otherwise applicable under this **Certificate**. The decision of the external appeal agent shall be binding on all parties.

Q. **Prosthetic Appliances Benefits.**

The **Member's** initial provision and replacement of a prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease or injury or congenital defects is covered, when such device is prescribed by a **Participating Provider**, administered through a **Participating** or designated prosthetic **Provider** and pre-authorized by **HMO**. Coverage includes repair and replacement when due to congenital growth. Instruction and appropriate services required for the **Member** to properly use the item (such as attachment or insertion) are covered. Covered prosthetic appliances include those items covered by Medicare unless excluded in the Exclusions and Limitations section of this **Certificate**. **HMO** reserves the right to provide the most cost efficient and least restrictive level of service or item which can be safely and effectively provided.

R. **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 below. 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.

Coverage does not include:

1. experimental injectable drugs or medications, or injectable 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), except that this does not apply to injectable drugs or medications used for the treatment of cancer or HIV when the off-label use of the drug has not been approved by the FDA for that indication. Please note that all denials of coverage based on the **Experimental or Investigational Procedures** exclusion are subject to the external appeal provision in the Claim Procedures/Complaint and Appeal section of the **Certificate**;

2. needles, syringes and other injectable aids;

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

4. injectable drugs related to the treatment of **Infertility**, contraception, and performance enhancing steroids.

S. **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.

T. **Infertility Services.**

- **Basic Infertility Services Benefits.**

  Benefits include only those **Infertility** services provided to a **Member**: a) by a **Participating Provider** to diagnose **Infertility**; and b) by a **Participating Infertility Specialist** to surgically treat the underlying medical cause of **Infertility**. Benefits also include **Hospital** or surgical or medical care for diagnosis and treatment of correctable medical conditions where the medical condition results in **Infertility**.

- **Comprehensive Infertility Services Benefits.**

  Member Eligibility. To be eligible for benefits, a **Member** must be covered under the **Certificate** as a **Subscriber,** or a **Covered Dependent**, and meet the definition of **Infertile** or **Infertility** as defined in the definition section of this **Certificate**. **Members** must be 21 through 44 years of age.

  If a **Member** meets the eligibility requirements above, Comprehensive **Infertility** Services are covered when provided by a **Participating Infertility Specialist** for any **Hospital**, medical, or surgical procedures which would correct malformation, disease, or dysfunction resulting in **Infertility** upon pre-authorization by **HMO**. These services include, but are not limited to, the following:

  1. ovulation induction;

  2. artificial insemination (AID, AIH, IUI);

  3. ultrasound of ovaries at the **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;

  4. post-coital test;

  5. hysterosalpingogram;

  6. laparoscopy;

  7. sono-hysterogram;

  8. blood tests;

  9. endometrial biopsy;

  10. hysteroscopy;

  11. semen analysis; and

  12. testis biopsy for a male **Member** with a **Referral** from his **PCP**.

  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** 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.

U. **Additional Benefits.**

- **Subluxation Benefits**.

  Services by a **Participating Provider** when **Medically Necessary** and upon prior **Referral** issued by the **PCP** are covered. Benefits include chiropractic care in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

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

- **Hospital Outpatient Facility Ambulatory Care.**

  The following ambulatory care in **Hospital** outpatient facilities is covered, provided that such services and medications are related to and necessary for the treatment or diagnosis of the **Member's** illness or injury and ordered by a **Physician**.

  1. Diagnostic x-rays.

  2. Laboratory and pathological examinations.

  3. Physical therapy, provided that services are to be furnished in connection with the same illness for which the **Member** had been hospitalized or in connection with surgical care. Physical therapy benefits must commence within 6 months from the date of discharge from a **Hospital** or the date surgical care was rendered. Benefits will cease after 365 days from the date of discharge from a **Hospital** or the date surgical care was rendered.

  4. Radiation therapy.

  5. Services and medications used for non-experimental cancer chemotherapy and cancer hormone therapy.

- **Cancer Treatment Benefits.**

  The following benefits are covered upon **Referral** issued by the **Member's PCP**.

  1. Inpatient care in a **Participating Hospital** for such periods as is determined by the attending **Physician** in consultation with the **Member** to be medically appropriate after the **Member** has undergone a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy is covered.

  2. Second medical opinion by an appropriate **Specialist**, including but not limited to a **Specialist** affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer is covered. The **Member** must obtain a prior **Referral**, and coverage for a second medical opinion may be obtained from a **Participating** or non-participating **Specialist**. The **Specialist Copayment** listed on the Schedule of Benefits applies.

3. Reconstructive surgery by a **Participating Provider** following mastectomy surgery for all stages of reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance in the manner determined by the **Physician** and the **Member** to be appropriate are covered.

- **Durable Medical Equipment Benefits.**

  Durable Medical Equipment will be provided when pre-authorized by **HMO**. The wide variety of **Durable Medical Equipment** and continuing development of patient care equipment makes it impractical to provide a complete listing, therefore, the **HMO** Medical Director has the authority to approve requests on a case-by-case basis. Covered **Durable Medical Equipment** includes those items covered by Medicare unless excluded in the Exclusions and Limitations section of this **Certificate**. **HMO** reserves the right to provide the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **HMO**.

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

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

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

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

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

EXCLUSIONS AND LIMITATIONS

A. **Exclusions.**

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

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

- Charges incurred outside of the United States, its possessions or the countries of Canada and Mexico.

- **Cosmetic Surgery**, except that **Cosmetic Surgery** shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a **Covered Dependent** child which has resulted in a functional defect.

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

- **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, care or treatment to sound natural teeth necessary due to accidental injury for 12 months following the date of such injury, or care or treatment necessary due to congenital disease or anomaly.

- Diagnosis and Treatment of **Infertility** in connection with:

  a. In-Vitro fertilization, Gamate intrafallopian tube transfers or zygote intrafallopian tube transfers;
  b. The reversal of elective sterilizations
  c. Sex change procedures
  d. Cloning
  e. Procedures deemed to be experimental in accordance with standards of ASRM.

- Hearing aids, including charges for examinations or adjustments.

- 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**.

- Payment for benefits for which Medicare or government program (except Medicaid) is the primary payer.

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

- 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, for which benefits are provided under any state or Federal workers' compensation, employers' liability or occupational disease law. However, if proof is furnished to **HMO** that the **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.

- Vision care services and supplies, including but not limited to, charges for examinations to determine the need for (or change of) eyeglasses or lenses of any type except initial replacements for loss of a natural lens, eye surgery such as radial keratotomy when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness), or astigmatism (blurring), or exams for the correction of vision, and radial keratotomy eye surgery including visual acuity improvements and related procedures to correct refractive errors.

B. **Limitations.**

- In the event there are 2 or more alternative **Medical Services** which in the sole judgment of **HMO** are equivalent in quality of care, **HMO** reserves the right to provide coverage only for the least costly **Medical Service**, as determined by **HMO**, provided that **HMO** pre-authorizes the **Medical Service** or treatment.

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

TERMINATION OF COVERAGE

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

A. **Termination of Subscriber Coverage.**

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

1. employment terminates;

2. the **Group Agreement** terminates;

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

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

B. **Termination of Dependent Coverage.**

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

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

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

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

C. **Termination For Cause.**

HMO may terminate coverage for cause:

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

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

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

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

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

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

A **Member** may request that **HMO** conduct an **Appeal** hearing, as described in the Claim Procedure/Complaints and Appeals 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 an **Appeal** 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** Claim Procedures/Complaints and Appeals to register a complaint against **HMO**. The **Appeal** process described in the preceding paragraph applies only to those terminations affected pursuant to the Termination For Cause subsection of this **Certificate**.

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

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

CONTINUATION AND CONVERSION

A. **COBRA Continuation Coverage.**

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

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

1. Minimum Size of Group:

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

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

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

3. Loss of coverage due to:

   a. divorce or legal separation, or

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

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

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

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

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

   a. the last day of the 18 month period.

   b. the last day of the 36 month period.

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

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

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

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

5. Extensions of Coverage Periods:

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

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

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

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

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

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

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

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

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

1. the date of discharge from such inpatient stay;

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

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

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

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

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

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

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

This extension of benefits shall only:

1. commence when a Medical Service is rendered for the condition causing Total Disability while the Member is covered under this Certificate; and

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

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

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

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

   c. after a period of twelve (12) months in which benefits under such coverage are provided to the **Member**.

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

D. **Continuation of Coverage under New York State Law.**

Subscribers and any **Covered Dependents** are eligible to continue coverage under this **Certificate** if coverage ceases due to termination of employment or membership in the class or classes eligible for coverage under the **Group Agreement**, subject to the terms and conditions of this **Certificate**.

1. Coverage shall not be available for:

   a. any person who is covered, becomes covered, or could be covered under Medicare; or

   b. an employee, member or dependent who is covered, becomes covered, or could be covered as an employee, member or dependent by any other insured or uninsured arrangement which provides **Hospital**, surgical or medical coverage for individuals in a group which does not contain any exclusion or limitation with respect to any pre-existing condition of such employee, member or dependent.

2. A **Member** who wishes continuation of coverage under New York law must request such continuation in writing within the 60-day period following the later of:

   a. the date of termination; or

   b. the date the **Subscriber** is sent notice by first class mail of the right of continuation by the **Contract Holder**.

3. A **Member** electing continuation must pay to the **Contract Holder**, but not more frequently than on a monthly basis in advance, the amount of the required **Premium** payment, but not more than 102% of the group rate for the benefits being continued under the **Certificate** on the due date of each payment. The **Member's** written election of continuation, together with the first **Premium** payment required to establish **Premium** payment on a monthly basis in advance, must be give to the **Contract Holder** within 60 days of the date the **Member's** benefits would otherwise terminate.

4. A **Member's** continuation of benefits under this **Certificate** shall terminate at the first to occur of the following:

   a. 18 months after the date the **Member's** benefits under the **Group Agreement** would otherwise have terminated because of termination of employment or membership; or

b. the end of the period for which **Premium** payments were made, if the **Member** fails to make timely payment of a required **Premium** payment; or

c. in the case of an eligible dependent, 36 months after the date the dependent's benefits under the **Group Agreement** would otherwise have terminated by reason of:

i. death of the **Subscriber**;
ii. the divorce or legal separation of the **Subscriber** from a dependent spouse;
iii. the **Subscriber** becoming entitled to benefits under Medicare; or
iv. a dependent child ceasing to be a **Covered Dependent** under the generally applicable requirements of this **Certificate**.

5. In the case of a **Member** who is determined, under title II or title XVI of the Social Security Act, to have been disabled at the time of termination of employment or membership, 29 months after the date the **Member's** benefits under the **Group Agreement** would otherwise have terminated because of termination of employment or membership or at any time during the first 60 days of continuation of coverage, provided, however, that if the **Member** is no longer disabled, the benefits provided in this section shall terminate the later of:

i. 18 months after the date the **Member's** benefits under the **Group Agreement** would otherwise have terminated because of termination of employment or membership; or

ii. the month that begins more than 31 days after the date of the final determination under title II or title XVI of the United States Social Security Act that the **Member** is no longer disabled; or

iii. the date on which the **Group Agreement** is terminated or, in the case of a **Subscriber**, the date his employer terminated participation under the **Group Agreement**. However, if the **Contract Holder** replaced coverage under the **Group Agreement** with similar coverage under another group contract, the **Member** shall have the right to become covered under the other group contract, for the balance of the period that he would have remained covered under this prior **Certificate**. The minimum level of benefits to be provided by the other group contract shall be the applicable level of benefits under this **Certificate** reduced by any benefits payable under this **Certificate**, and this **Certificate** shall continue to provide benefits to the extent of its accrued liabilities and extensions of benefits as if the replacement had not occurred.

Regarding groups with less than 20 **Subscribers**, continuation of coverage will cease on the date on which the **Subscriber** or **Dependent** first becomes, after the date of election, entitled to coverage under Medicare.

This continuation of coverage under New York law shall not be applicable where a continuation benefit is available to the **Member** pursuant to Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. § 1161 et seq. Or Chapter 6A of the Public Health Service Act, 42 U.S.C. § 300bb-1 et seq.

E. **Conversion Privilege.**

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

Conversion is not initiated by **HMO**. The conversion privilege set forth in this subsection must be initiated by the eligible **Member**. The **Contract Holder** is responsible for giving written notice of the conversion privilege in accordance with its normal procedures and within 90 days of the date of termination; 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**, such person may, within 45 days after termination of coverage under this **Certificate**, convert to individual coverage with **HMO**, effective as of the date of such termination, without evidence of insurability provided that **Member's** coverage under this **Certificate** terminated for 1 of the following reasons:

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

b. the **Subscriber** ceased to meet the eligibility requirements as described in this **Certificate** and on the Schedule of Benefits, in which case the **Subscriber** and **Subscriber's** dependents who are **Members** pursuant to this **Certificate**, if any, are eligible to convert;

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

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

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

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

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.

Member may submit an oral complaint in connection with: (i) a denial of, or failure to pay for, a referral; or (ii) a determination as to whether a benefit is covered pursuant to the terms of this **Certificate**. **HMO** then may require the **Member** to sign a written acknowledgement of the complaint, prepared by **HMO**, summarizing the nature of the complaint. **Member** shall promptly mail the signed acknowledgement back to the **HMO**, along with any amendments, in order to initiate the complaint. If **HMO** does not require such a signed acknowledgement, an oral complaint shall be initiated at the time of the telephone call.

Within fifteen days of receipt of the complaint, **HMO** shall provide written acknowledgement of the complaint, including the name, address and telephone number of the individual or department designated by **HMO** to respond to the grievance.

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

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

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

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

Utilization Review

HMO Timeframe for Notification of an Adverse Benefit Determination	
Type of Claim	**HMO Response Time from Receipt of Claim**
Urgent Care Claim. A claim for medical care or treatment where delay could seriously jeopardize the life or health of the **Member,** the ability of the **Member** to regain maximum function; or subject the **Member** to severe pain that cannot be adequately managed without the requested care or treatment.	As soon as possible but not later than 72 hours
Pre-Service Claim. A claim for a benefit that requires pre-authorization of the benefit in advance of obtaining medical care.	Within 3 business days
Concurrent Care Claim Extension. A request to extend a course of treatment previously pre-authorized by **HMO**.	Within 1 business day
Concurrent Care Claim Reduction or Termination. Decision to reduce or terminate a course of treatment previously pre-authorized by **HMO**.	Within 1 business day
Post-Service Claim. A claim for a benefit that is not a pre-service claim.	Within 30 calendar days

Non-Utilization Review

HMO Timeframe for Notification of an Adverse Benefit Determination	
Type of Claim	**HMO Response Time from Receipt of Claim**
Urgent Care Claim. A claim for medical care or treatment where delay could seriously jeopardize the life or health of the **Member,** the ability of the **Member** to regain maximum function; or subject the **Member** to severe pain that cannot be adequately managed without the requested care or treatment.	As soon as possible but not later than 48 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**, but no later than 30 calendar days
Post-Service Claim. A claim for a benefit that is not a pre-service claim.	Within 30 calendar days

COMPLAINTS AND APPEALS

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

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

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

A. **Complaints.**

If the **Member** is dissatisfied with the administrative services the **Member** receives from the **HMO** or wants to complain about a **Participating Provider,** call or write Member Services within 30 calendar days of the incident at (800) 323-9930. 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 15 business days of the receipt of the **Complaint**, including the name, address and telephone number of the individual designated by **HMO** to respond to the **Appeal** and what information, if any, must be provided in order for **HMO** to render a decision; unless additional information is needed and it cannot be obtained within this time frame. The response will tell the **Member** what the **Member** needs to do to seek an additional review.

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

The **Member** will receive written notice of an adverse benefit determination from the **HMO**. The notice will include the reason for the decision and it will explain what steps must be taken if the **Member** wishes to **Appeal.** The notice will also identify the **Member's** rights to receive additional information that may be relevant to an **Appeal**. Requests for an **Appeal** must be made in writing within 180 calendar days from the date of the notice.

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

HMO shall provide written acknowledgement of the filing of the **Appeal** to the appealing party within 15 days of such filing.

The **HMO** provides for two levels of **Appeal** of the adverse benefit determination. The **Member** must complete the two levels of **HMO** review before bringing a lawsuit against the **HMO**. 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.

Utilization Review

HMO Timeframe for Responding to an Adverse Benefit Determination Appeal		
Type of Claim	**Level One Appeal HMO Response Time from Receipt of Appeal**	**Level Two Appeal HMO Response Time from Receipt of Appeal**
Urgent Care Claim. A claim for medical care or treatment where delay could seriously jeopardize the life or health of the **Member,** the ability of the **Member** to regain maximum function; or subject the **Member** to severe pain that cannot be adequately managed without the requested care or treatment.	Within 36 hours Review provided by **HMO** personnel not involved in making the adverse benefit determination.	Within 36 hours Review provided by **HMO** Appeals Committee.
Pre-Service Claim. A claim for a benefit that requires approval of the benefit in advance of obtaining medical care.	Within 15 calendar days Review provided by **HMO** personnel not involved in making the adverse benefit determination.	Within 15 calendar days Review provided by **HMO** Appeals Committee.
Concurrent Care Claim Extension. A request to extend or a decision to reduce a previously approved course of treatment.	Treated like an urgent care claim or within 2 business days 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 2 business days Review provided by **HMO** personnel not involved in making the adverse benefit determination.	Within 30 calendar days Review provided by **HMO** Appeals Committee.

Non-Utilization Review

HMO Timeframe for Responding to an Adverse Benefit Determination Appeal		
Type of Claim	**Level One Appeal HMO Response Time from Receipt of Appeal**	**Level Two Appeal HMO Response Time from Receipt of Appeal**
Urgent Care Claim. A claim for medical care or treatment where delay could seriously jeopardize the life or health of the **Member,** the ability of the **Member** to regain maximum function; or subject the **Member** to severe pain that cannot be adequately managed without the requested care or treatment.	Within 36 hours Review provided by **HMO** personnel not involved in making the adverse benefit determination.	Within 36 hours Review provided by **HMO** Appeals Committee.
Pre-Service Claim. A claim for a benefit that requires approval of the benefit in advance of obtaining medical care.	Within 15 calendar days Review provided by **HMO** personnel not involved in making the adverse benefit determination.	Within 15 calendar days Review provided by **HMO** Appeals Committee.
Concurrent Care Claim Extension. A request to extend or a decision to reduce a previously approved course of treatment.	Treated like an urgent care claim or a pre-service claim depending on the circumstances.	Treated like an urgent care claim or a pre-service claim depending on the circumstances.
Post-Service Claim. Any claim for a benefit that is not a pre-service claim.	Within 30 calendar days Review provided by **HMO** personnel not involved in making the adverse benefit determination.	Within 30 calendar days Review provided by **HMO** Appeals Committee.

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

C. **External Appeal.**

1. Right to an External Appeal

Under certain circumstances, the **Member** has the right to an external appeal of a denial of coverage. Specifically, if the **HMO** has denied coverage on the basis that the service is not **Medically Necessary** or is an **Experimental or Investigational Procedure**, the **Member** may **Appeal** that decision to an External Appeal Agent, an independent entity certified by the State to conduct such appeals.

a. Right to **Appeal** a determination that a service is not **Medically Necessary**

If the **HMO** has denied coverage on the basis that the service is not **Medically Necessary**, the **Member** may **Appeal** to an External Appeal Agent if the **Member** satisfies the following criteria listed below:

i. The service, procedure or treatment must otherwise be a **Covered Service** under this **Certficate**; and

ii. The **Member** must have received a final adverse determination through the first level of the **HMO's** internal review process and the **HMO** must have upheld the denial or the **Member** and the **HMO** must agree in writing to waive any internal appeal.

b. Right to **Appeal** a determination that a service is **Experimental or Investigational**.

If a **Member** has been denied coverage on the basis that the service is an **Experimental or Investigational Procedure**, you must satisfy the following criteria:

i. The service must otherwise be a **Covered Service** under this **Certificate**; and

ii. **Member** must have received a final adverse determination through the first level of the **HMO's** internal appeal process and the Plan must have upheld the denial or the **Member** and the **HMO** must agree in writing to waive any internal appeal.

In addition, the **Member's** attending **Physician** must certify that the **Member** has a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one which, according to the current diagnosis of the attending **Physician**, has a high probability of death. A "disabling condition or disease" is any medically determinable physical or medical impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than twelve (12) months, which renders the **Member** unable to engage in any substantial gainful activities. In the case of a dependent child under the age of eighteen (18), a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

The **Member's** attending **Physician** must also certify that the life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered by the **Certificate** or one for which there exists a clinical trial (as defined by law.)

In addition, the **Member's** attending **Physician** must have recommended at least one of the following:

i. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to the **Member** than any standard **Covered Service** (only certain documents will be considered

in support of this recommendation – the **Member's** attending **Physician** should contact the State in order to obtain current information as to what documents will be considered acceptable); or

ii. A clinical trial for which you are eligible (only certain clinical trials can be considered).

For the purposes of this section, the **Member's** attending **Physician** must be a licensed, board certified or board eligible **Physician** qualified to practice in the area appropriate to treat the **Member's** life-threatening or disabling condition or disease.

c. The external appeal process.

If, through the first level of the **Certificate's** internal appeal process, the **Member** has received a final adverse determination upholding a denial of coverage on the basis that the service is not **Medically Necessary** or is an E**xperimental or Investigational Procedure**, the **Member** has forty-five (45) days from receipt of such notice to file a written request for an external appeal. If the **Member** and the **HMO** have agreed to waive any internal appeal, the **Member** has forty-five (45) days from the receipt of such waiver to file a written request for an external appeal. The **HMO** will provide an external appeal application with the final adverse determination issued through the first level of the **Certificate's** internal appeal process or its written waiver of an internal appeal.

The **Member** may also request an external appeal application from the New York State Department of Insurance, telephone number (800) 400-8882. The **Member** shall submit the completed application to the New York State Department of Insurance at the address listed in the application. If the **Member** satisfies the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent. The **Member** will have the opportunity to submit additional documentation with the request. If the External Appeal Agent determines that the information the **Member** submits represents a material change from the information on which the **HMO** based its denial, the External Appeal Agent will share this information with the **HMO** in order for it to exercise its right to reconsider its decision. If the **HMO** chooses to exercise this right, the **HMO** will have three (3) business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), the **HMO** does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within thirty (30) days of receipt of the completed application. The External Appeal Agent may request additional information from the **Member**, the **Member's Physician** or the **HMO**. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify the **Member** in writing of its decision within two (2) business days.

If the **Member's** attending **Physician** certifies that a delay in providing the service that has been denied poses an imminent or serious threat to the **Member's** health, the **Member** may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within three (3) days of receipt of the completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify the **Member** and the **HMO** by telephone or facsimile of that decision. The External Appeal Agent must also notify the **Member** in writing of its decision.

If the External Appeal Agent overturns the **HMO's** decision that a service is not **Medically Necessary** or approves coverage of an **Experimental or Investigational Procedure**, the **HMO** will provide coverage subject to the other terms and condition of

this **Certificate**. If the External Appeal Agent approves coverage of an **Experimental or Investigational Procedure** that is part of a clinical trial, the **HMO** will only cover the costs of services required to provide treatment to the **Member** according to the design of the trial. The **HMO** shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this **Certificate** for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both the **Member** and **HMO**. The External Appeal Agent's decision is admissible in any court proceeding.

d. Responsibilities of the **Member**.

It is the responsibility of the **Member** to initiate the external appeals process. The **Member** may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. The **Member** may designate an authorized representative at any time to pursue an external appeal. The **Member's** attending **Physician** may file an external appeal application on behalf of the **Member**, after the health care services have been provided, but only if the **Member** has consented to this in writing.

Under New York State law, the **Member's** completed request for **Appeal** must be filed within 45 days of either the date upon which the **Member** received written notification from the **HMO** that it has upheld a denial of coverage or the date upon which the **Member** receives a written waiver of any internal appeal. The **HMO** has no authority to grant an extension of this guideline.

e. Covered Services and Exclusions.

In general, the **HMO** does not cover **Experimental or Investigational Procedures**. However, the **HMO** shall cover an E**xperimental or Investigational Procedure** approved by an External Appeal Agent in accordance with this section of the **Certificate**. If the External Appeal Agent approves coverage of an **Experimental or Investigational Procedure** that is part of a clinical trial, the **HMO** will only cover the costs of services required to provide treatment to you according to the design of the trial. The **HMO** shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this **Certificate** for non-experimental or non-investigational treatments provided in such clinical trial.

D. **Record Retention.**

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

E. **Fees and Costs.**

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

COORDINATION OF BENEFITS

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

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

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

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

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

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

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

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

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

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

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

THIRD PARTY LIABILITY AND RIGHT OF RECOVERY

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

an accident or alleged negligence. The right of recovery will only be exercised by **HMO** when the amounts received by the **Member** through a third party settlement or satisfied judgment are specifically identified in the settlement or judgment as the amounts previously paid by **HMO** for the same **Medical Services** and benefits.

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

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

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

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

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

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

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

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

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

RESPONSIBILITY OF MEMBERS

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

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

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

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

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

GENERAL PROVISIONS

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

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

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

1. disclose all facts pertaining to the care, treatment and physical condition of the **Member** to **HMO**, or a medical, dental, or mental health professional that **HMO** may engage to assist it in reviewing a treatment or claim;
2. render reports pertaining to the care, treatment and physical condition of the **Member** to **HMO**, or a medical, dental, or mental health professional that **HMO** may engage to assist it in reviewing a treatment or claim; and
3. permit copying of the **Member's** records by **HMO**.

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

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

E. **Independent Contractor Relationship.**

1. **Participating Providers**, non-participating **Providers**, institutions, facilities or agencies are neither agents nor employees of **HMO**. Neither **HMO** nor any **Member** of **HMO** is an agent or employee of any **Participating Provider**, non-participating **Provider**, institution, facility or agency.

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

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

4. **HMO** cannot guarantee the continued participation of any **Provider** or facility with **HMO**.

   a. In the event a **PCP** terminates its contract or is terminated by **HMO**, **HMO** shall provide notification to each affected **Subscriber** within 15 days of the termination of a **PCP** contract, if the **Subscriber** or any **Dependent** of the **Subscriber** is currently enrolled in the **PCP's** office. Any 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**.

   b. In the event any other **Participating Provider** terminates its contract or is terminated by **HMO**, **HMO** shall provide notification to each affected **Subscriber** who is receiving an ongoing course of treatment provided that **HMO** is aware of such ongoing course of treatment. Notification will be provided within 15 days of the termination of the **Provider's** contract. The notice shall describe the procedures for continuing care pursuant to state law and for choosing an alternative **Participating Provider**.

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

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

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

H. **Limitation on Services.** Except in cases of **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**.

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

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

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

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

M. 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**.

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

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

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

DEFINITIONS

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

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

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

- **Continuous Confinement.** Consecutive days of in-**Hospital** service received as an inpatient, or successive confinements when discharge from and readmission to the **Hospital** occur within a period of time not more than 90 days or successive confinements due to the same or related causes unless between such confinements a **Member** has been actively at work, if an employee, or engaged in normal activity if not an employee, for a period of not more than 90 days. A confinement for an accident shall not be combined with another confinement for an illness in determining **Continuous Confinement**.

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

- **Contract Year.** A period of 1 year commencing on the **Contract Holder's Effective Date of Coverage** and ending at 12:00 midnight on the last day of the 1 year period.

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

- **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** does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a **Covered Dependent** child which has resulted in a functional defect.

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

- **Covered Benefits.** Those **Medically Necessary Services** and supplies set forth in this **Certificate**, which are covered subject to all of the terms and conditions of the **Group Agreement** and **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.** Help in transferring, eating, dressing, bathing, toileting and other such related activities.

- **Detoxification.** The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed **Physician**, while keeping the physiological risk to the patient at a minimum.

- **Durable Medical Equipment (DME).** Equipment, as determined by **HMO**, which is a) made for and mainly used in the treatment of a disease or injury; b) made to withstand prolonged use; c) suited for use

while not confined as an inpatient in the **Hospital**; d) not normally of use to persons who do not have a disease or injury; e) not for use in altering air quality or temperature; and f) not for exercise or training.

- **Effective Date of Coverage.** The commencement date of coverage under this **Certificate** as shown on the records of **HMO**.

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

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

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

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

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

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

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

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

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

  8. it has not been proven safe or efficacious.

- **Group Agreement.** The **Group Agreement** between **HMO** and the **Contract Holder**, including the Group Application, this **Certificate**, including the Schedule of Benefits, any riders, and any amendments, endorsements, inserts, or attachments, as subsequently amended by operation of law and as filed with and approved by the applicable public authority.

- **Health Professional(s).** A **Physician** or other professional who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides **Medical Services** which are within the scope of the individual's license or certificate.

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

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

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

- **Hospice Care.** A program of care that is provided by a **Hospice** organization certified pursuant to state law or under a similar certification process required by the state in which the Hospice organization is

located, and is focused on a palliative rather than curative treatment for **Members** who have a medical condition and a prognosis of less than 6 months to live.

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

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

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

- **Medical Emergency.** The existence of a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of such person or others in serious jeopardy; or (ii) serious impairment to such person's bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

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

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

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

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

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

- **Open Enrollment Period.** A period each calendar year, when eligible enrollees of the **Contract Holder** may enroll in **HMO** without a waiting period or exclusion or limitation based on health status or, if already enrolled in **HMO**, may transfer to an alternative health plan offered by the **Contract Holder**.

- **Partial Hospitalization.** The provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a **Hospital** or **Non-Hospital Facility** which is licensed as an alcohol or drug abuse or mental illness treatment program by the appropriate regulatory authority, and

which is designed for a patient or client who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care.

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

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

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

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

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

- **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.
(NEW YORK)

METHOD OF PAYMENT AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

The Method of Payment Section of the **Certificate** is deleted and replaced in its entirety as follows:

METHOD OF PAYMENT

The **Member** must pay any applicable **Copayments** for **Covered Benefits.**

Maximum Out-of-Pocket Limit.

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

Calculations; Determination of Benefits.

A **Member's** financial responsibility for the costs of services will be calculated on the basis of when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of stays that occur in more than 1 **calendar year**. It is solely within the discretion of **HMO** to determine when benefits are covered under this **Certificate**.

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

AETNA HEALTH INC.
(NEW YORK)

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"** and **"Skilled Nursing Facility"** are hereby deleted and replaced with the following definitions:

- **Custodial Care.** Services and supplies that are not **Medically Necessary** and 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.

- **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,** as defined under Medicare (Title XVIII of the Social Security Act).

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 **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 appropriate care.

1. Part-time or intermittent home nursing care provided by or under the supervision of a registered nurse.

2. Part-time or intermittent services of a home health aide. These services are covered only when they consist primarily of caring for the patient.
3. Medical social services, medical supplies, drugs and medications prescribed by a **Physician**, and laboratory services by or on behalf of a certified or licensed home health agency to the extent such items would have been covered or provided if the **Member** had been hospitalized or confined in a **Skilled Nursing Facility**. Treatment must be prescribed by the **Member's PCP** for the treatment of the **Member's** medical condition.
4. Short-term physical, speech or occupational therapy is also covered.

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

AETNA HEALTH INC.
(NEW YORK)

CERTIFICATE OF COVERAGE AMENDMENT

Effective Date: January 1, 2013

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

Item 3 of the section "Cancer Treatment Benefits" of the **Certificate** is replaced by the following:

3. Coverage includes (i) reconstructive surgery by a **Participating Provider** following a mastectomy or partial mastectomy, including an implant and areolar reconstruction of the breast on which the surgery has been performed, and (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance with the reconstructed breast, and (iii) physical therapy to treat complications of the mastectomy or partial mastectomy, including lymph edemas, in the manner determined by the **Physician** and the **Member** to be appropriate.

AETNA HEALTH INC.
(NEW YORK)

DIABETIC AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Diabetic Equipment, Supplies and Education provision of the Covered Benefits section of the **Certificate** is hereby deleted in its entirety and replaced with the following:

9. Diabetic Equipment, Supplies and Education. The following equipment, supplies and education services for the treatment of diabetic conditions are covered when ordered by the **Member's PCP** " or other licensed health professional" and obtained through a **Participating Provider**:

    a. Blood glucose monitors and blood glucose monitors for the visually impaired;

    b. Control solutions used in blood glucose monitors;

    c. Data management systems;

    d. Test strips for glucose monitors and visual reading and urine test strips;

    e. Insulin;

    f. Injection aids;

    g. Cartridges for the visually impaired;

    h. Syringes, insulin pumps and appurtenances thereto;

    i. Insulin infusion devices;

    j. Oral agents for controlling blood sugar;

    k. Glucagon for injection to increase blood glucose concentration;

    l. Lancets and automatic lancing devices;

    m. Urine testing products for glucose and ketones;

    n. Alcohol swabs;

    o. Disposable insulin cartridges and pen cartridges;

    p. All insulin preparations;

    q. Insulin pumps and equipment for the use of the pump including batteries;

    r. Insulin infusion devices;

    s. Such other equipment and related supplies required by the commissioner of the department of health; and

t. Coverage for diabetes self-management education, including information on proper diets.

Such coverage for self-management education and education relating to diet shall be limited to visits **Medically Necessary** upon the diagnosis of diabetes, where a **Physician** diagnoses a significant change in the patient's symptoms or conditions which necessitate changes in a patient's self-management, or where reeducation or refresher education is necessary. Coverage for self-management education and education relating to diet shall also include home visits when **Medically Necessary**.

AETNA HEALTH INC.
(NEW YORK)

MEDICAL SUPPORT AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

Subsection B.4.a of the Eligibility and Enrollment section of the **Certificate** is hereby deleted and replaced with the following:

a. Qualified Medical Child Support Order.

Coverage is available for a dependent child if there is a qualified medical child support order requiring the **Subscriber** to provide dependent health coverage. The child must meet the definition of a **Covered Dependent**.

Written request for coverage must be made within 31 days of the court order. Coverage for the child will become effective on the date of such court order. If you are the non-custodial parent, written request for coverage for the child may be given by the person who has custody of the child. If you are not covered, you will be enrolled for coverage. Your coverage will become effective on the date of the court order. If request is not made within such 31 days, coverage for the child will be subject to all of the terms of this **Certificate**.

AETNA HEALTH INC.
(NEW YORK)

HIPAA SPECIAL ENROLLMENT/PORTABILITY AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

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

6. Special Enrollment Period.

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

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

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

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

b. the eligible individual or eligible dependent previously provided a written statement declining coverage under **HMO** because the eligible individual or dependent had such other coverage, but only if such written statement is required by the employer, the employer gives written notice to the eligible individual or dependent of this requirement and the notice explains the consequences of the failure on the part of the eligible individual or dependent to provide such written statement;

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, but is not limited to, 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, or of coverage under any plan which requires the member to reside, live or work in **HMO** or plan's service area in order to receive benefits, and **HMO** or plan coverage ends because member no longer resides, lives or works in **HMO** or plan's service area;
- plan ceases to offer coverage to a group of similarly situated individuals;
- cessation of a dependent's status as an eligible dependent;
- termination of benefit package.

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

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

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

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

Special Enrollment Period When a New Eligible Dependent is Acquired:

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

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

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

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

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

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

- **Creditable Coverage.** Coverage of the **Member** under a group health plan (including a governmental or church plan), a health insurance coverage (either group or individual insurance), Medicare, Medicaid, a military-sponsored health care (CHAMPUS), a program of the Indian Health Service or tribal organization, 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.
(NEW YORK)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

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

Residential Treatment Facility – (Mental Disorders)

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

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

Residential Treatment Facility – (Alcoholism and Drug Abuse)

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

- On-site licensed **Behavioral Health Provider** 24 hours per day/7 days a week
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a **Physician.**
- Has access to necessary medical services 24 hours per day/7 days a week.
- If the member requires detoxification services, must have the availability of on-site medical treatment 24 hours per day/7days a week, which must be actively supervised by an attending **Physician**.

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

AETNA HEALTH INC.
(NEW YORK)

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.
(NEW YORK)

CLINICAL REVIEW CRITERIA REQUESTS AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The following subsection **G. Clinical Review Criteria Requests** is added to the **HMO Procedure** section of the Aetna Health Inc. **Certificate**:

G. **Clinical Review Criteria Requests**

If a **Member** needs additional information on a specific clinical issue, he or she may request a Clinical Review Criteria by submitting written request to **HMO.** The written request must contain the following information:

- **Member's** name; address; and telephone number.
- A request for the clinical review criteria, which **HMO** would utilize in making a coverage determination involving a specific condition, treatment or device.

The written request should be sent to the following address:

Aetna Health Inc.
CRC Requests - Mail Code: F074
One Farr View
Cranbury, N.J. 08512

HMO will take into consideration the **Member's** individual situation in applying the Clinical Review Criteria.

For questions, or further assistance, **Member** should call the Member Services toll-free telephone number shown in the **Member's** Identification Card.

AETNA HEALTH INC.
(NEW YORK)

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:

L. **Rehabilitation Benefits.**

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

1. Cardiac and Pulmonary Rehabilitation Benefits.

   a. Cardiac rehabilitation benefits are available as part of a **Member's** inpatient **Hospital** stay. A limited course of outpatient cardiac rehabilitation is covered when **Medically Necessary** following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.

   b. Pulmonary rehabilitation benefits are available as part of a **Member's** inpatient **Hospital** stay. A limited course of outpatient pulmonary rehabilitation is covered when **Medically Necessary** for the treatment of reversible pulmonary disease states.

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.

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

AETNA HEALTH INC.
(NEW YORK)

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 **Third Party Liability 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 (a) associated with the Third Party injuries; or (b) specifically identified or allocated as benefits previously provided by **HMO** for such injuries in any recovery, settlement, judgment or compensation agreement. **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. In the event **Member** suffers injuries for which a Third Party is responsible (such as someone injuring the **Member** in an accident), and **HMO** provides benefits as a result of those injuries, **HMO** will be subrogated and succeed to the right of recovery against such Third Party to the extent of the benefits **HMO** has provided. This means that **HMO** has the right, independently of the **Member**, to proceed against the Third Party responsible for the **Member's** injuries to recover the benefits **HMO** has provided.

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 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 this Plan, but only to the extent such benefits are identified or allocated as benefits previously provided by **HMO** for such injuries in any recovery, settlement, judgment or compensation agreement. **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 (but only to the extent such benefits are identified or allocated as benefits previously provided by **HMO** for such expenses in any 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 (but only to the extent such benefits are identified or allocated as benefits previously provided by **HMO** for such expenses in any recovery, settlement, judgment or compensation agreement), 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 paid 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 paid 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 payment.

RECOVERY RIGHTS RELATED TO WORKERS' COMPENSATION

If benefits are provided by **HMO** for Illness or Injuries to a **Member** and **HMO** determines the **Member** received Workers' Compensation benefits for the same incident that resulted in the illness or injuries, **HMO** has the right to recover as described under the Subrogation and Right of Reimbursement provision. "Workers' Compensation benefits" includes benefits paid in connection with a Workers' Compensation claim, whether paid by an employer directly, a workers' compensation insurance carrier, or any fund designed to provide compensation for workers' compensation claims.

The Recovery Rights will be applied as follows:

For Compensable Claims:

a) **HMO** may exercise its Recovery Rights against the provider in the event that the work-related injury is deemed compensable either by the workers' compensation carrier, an order of the New York Workers' Compensation Board approving a settlement agreement that specifically identifies or allocates monetary sums directly attributable to expenses for which the insurer pays benefits; or by a final adjudication of the claim pursuant to New York Workers' Compensation laws. In such, case **HMO** may request that the provider rebill the workers' compensation carrier for medical treatment provided as a result of the compensable sickness or injury; or

b) **HMO** may exercise its Recovery Rights directly against the provider when the provider has previously been paid by the carrier directly, resulting in a duplicate payment; or

c) **HMO** may exercise its Recovery Rights directly against the workers' compensation carrier in an amount equal to the total benefits paid by **HMO** for compensable work-related sickness or injury.

For Claims Paid by Means of Settlement or Compromise:

d) **HMO** may exercise its Recovery Rights against the **Member** when the disputed claim is paid in a lump sum by means of settlement or compromise that specifically identifies or allocates monetary sums directly attributable to expenses for which the insurer pays benefits; or

e) **HMO** may exercise its Recovery Rights against the workers' compensation carrier when the disputed claim is paid in a lump sum by means of settlement or compromise that specifically identifies or allocates monetary sums directly attributable to expenses for which the insurer pays benefits.

HMO may exercise its Recovery Rights against the **Member** even though:

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

g) The amount of Workers' Compensation benefits due to medical or health care is not agreed upon or defined by the **Member** or the Workers' Compensation carrier.

By accepting benefits under this Plan, the **Member** or the **Member's** representatives agree:

a) To 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 work-related illness or injury sustained by the **Member**;

b) Cooperate with **HMO**, provide **HMO** with requested information, and do whatever is necessary to secure **HMO's** Rights of Recovery under this **Certificate**;

c) Give **HMO** a first-priority lien on any recovery, settlement or judgment or other source of compensation which may be had from any party to the extent of the full cost of all benefits associated with the work-related illness or injury provided by this Plan (but only to the extent such benefits are identified or allocated as benefits previously provided by **HMO** for such expenses in any 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 the work-related illness or injury provided by this Plan (but only to the extent such benefits are identified or allocated as benefits previously provided by **HMO** for such expenses in any recovery, settlement, judgment or compensation agreement), 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 paid by this Plan and insuring that any settlement specifically identifies or allocates monetary sums directly attributable to expenses for which the insurer pays benefits.

f) Serve as a constructive trustee for the benefit of this Plan over any settlement or recovery funds received as a result of the work-related illness or injury.

AETNA HEALTH INC.
(NEW YORK)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

Section A Primary Care Physician Benefits of the **Certificate** is amended as follows:

Item 5. a. iii is replaced by the following:

iii. Necessary immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Service, the Department of Health and in accordance with the minimum benefits mandated by the State of New York.

AETNA HEALTH INC.
(NEW YORK)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

- **Self-injectable Drug(s)**. Prescription drugs that are self-administered by injection.

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** as defined above which are eligible for coverage under the Prescription Plan Rider, are a **Covered Benefit** when an oral alternative drug is not available, unless specifically excluded below. Medications must be prescribed by a **Provider** licensed to prescribe federal legend prescription drugs or medicines. If preauthorization is required, the **Provider** must contact the **HMO** to obtain coverage for such drugs. With respect to **Self-injectable Drugs**, the **Member** is required to obtain covered **Self-injectable Drugs** from an **HMO Participating** pharmacy designated to fill **Self-injectable Drugs**, except for the following:

  Exceptions:

  Blood thinners (Arixtra, Fragmin, Innohep, Lovenox, Orgaran)
  Diabetic drugs (Insulin, Byetta, Glucagon, Symlin)
  Emergency Medications (Epinephrine Kits)
  Erectile Dysfunction Medications (Caverject, Edex)
  Migraine Medications (Imitrex)
  Multiple Sclerosis Medications (Betaseron)

  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.

  Coverage does not include:

  1. experimental injectable drugs or medications, or injectable 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), except that this does not apply to injectable drugs or medications used for the treatment of cancer or HIV when the off-label use of the drug has not been approved by the FDA for that indication. Please note that all denials of coverage based on the **Experimental or Investigational Procedures** exclusion are subject to the external appeal provision in the Claim Procedures/Complaints and Appeals section of the **Certificate**;

  2. needles, syringes and other injectable aids;

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

4. injectable drugs related to the treatment of non-covered **Infertility** services and performance enhancing steroids, unless **Medically Necessary**.

AETNA HEALTH INC.
(NEW YORK)

GENERAL PROVISIONS AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

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

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

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

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

AETNA HEALTH INC.
(NEW YORK)

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

Contract Holder Group Agreement Effective Date: January 1, 2013

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

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

Continuation Coverage for Dependent Students on Medical Leave of Absence

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

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

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

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

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

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

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

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

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

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

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

If:

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

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

3. this plan provides coverage for eligible dependents;

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

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

AETNA HEALTH INC.
(NEW YORK)

CERTIFICATE AMENDMENT
(CONTINUATION OF COVERAGE UNDER NEW YORK STATE LAW)

Contract Holder Group Agreement Effective Date: January 1, 2013

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

D. **Continuation of Coverage under New York State Law.**

Subscribers and any **Covered Dependents** are eligible to continue coverage under this **Certificate** if coverage ceases due to termination of employment or membership in the class or classes eligible for coverage under the **Group Agreement**, subject to the terms and conditions of this **Certificate**.

1. Coverage shall not be available for:

   a. any person who is enrolled, or becomes enrolled, under Medicare; or

   b. an employee, member or dependent who is covered, becomes covered, or could be covered as an employee, member or dependent by any other insured or uninsured arrangement which provides **Hospital**, surgical or medical coverage for individuals in a group which does not contain any exclusion or limitation with respect to any pre-existing condition of such employee, member or dependent.

2. A **Member** who wishes continuation of coverage under New York law must request such continuation in writing within the 60-day period following the later of:

   a. the date of termination; or

   b. the date the **Subscriber** is sent notice by first class mail of the right of continuation by the **Contract Holder**.

3. A **Member** electing continuation must pay to the **Contract Holder**, but not more frequently than on a monthly basis in advance, the amount of the required **Premium** payment, but not more than 102% of the group rate for the benefits being continued under the **Certificate** on the due date of each payment. The **Member's** written election of continuation, together with the first **Premium** payment required to establish **Premium** payment on a monthly basis in advance, must be give to the **Contract Holder** within 60 days of the date the **Member's** benefits would otherwise terminate, or the date the **Subscriber** is sent notice by first class mail of the right of continuation by the **Contract Holder**, whichever is later.

4. A **Member's** continuation of benefits under this **Certificate** shall terminate at the first to occur of the following:

   a. 36 months after the date the **Member's** benefits under the **Group Agreement** would otherwise have terminated because of termination of employment or membership; or

   b. the end of the period for which **Premium** payments were made, if the **Member** fails to make timely payment of a required **Premium** payment; or

c. in the case of an eligible dependent, 36 months after the date the dependent's benefits under the **Group Agreement** would otherwise have terminated by reason of:

i. death of the **Subscriber**;
ii. the divorce or legal separation of the **Subscriber** from a dependent spouse;
iii. the **Subscriber** becoming enrolled for benefits under Medicare; or
iv. a dependent child ceasing to be a **Covered Dependent** under the generally applicable requirements of this **Certificate**.

If **Member** has exhausted **Member's** coverage continuation benefits under Chapter 18 of the Employer Retirement Income Security Act, 29 U.S.C. § 1161 et seq. Or Chapter 6A of the Public Health Service Act, 42 U.S.C. § 300bb-1 et seq. law, **Member** will be given the opportunity to continue coverage under this continuation provision for up to 36 months from the date **Member's** continuation began if **Member** was entitled to less that 36 months continuation benefits under Chapter 18 of the Employer Retirement Income Security Act, 29 U.S.C. § 1161 et seq. or Chapter 6A of the Public Health Service Act, 42 U.S.C. § 300bb-1 et seq.

Regarding groups with less than 20 **Subscribers**, continuation of coverage will cease on the date on which the **Subscriber** or **Dependent** first becomes, after the date of election, enrolled for coverage under Medicare.

This continuation of coverage under New York law shall not be applicable where a continuation benefit is available to the **Member** pursuant to Chapter 18 of the Employer Retirement Income Security Act, 29 U.S.C. § 1161 et seq. or Chapter 6A of the Public Health Service Act, 42 U.S.C. § 300bb-1 et seq.

AETNA HEALTH INC.
(NEW YORK)

APPEALS PROCEDURE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The section "**Appeals** Procedure"“Claims Procedures/**Grievance**/Utilization Review/**Appeal**” of the **Certificate** is hereby replaced with the following section "**Appeal**s Procedure:"

Appeals Procedure

Definitions

Adverse determination: A denial; reduction; termination of; or failure to provide (in whole or in part) a service because it is determined to be an **Experimental or Investigational Procedure** or not **Medically Necessary** or appropriate.

Such **adverse determination** may be based on, among other things:

- A **Member's** eligibility for coverage;
- Plan limitations or exclusions;
- The results of any Utilization Review activities (determination as to whether or not an admission, extension of stay, or other health care service or supply is **Medically Necessary**, based on the information provided).

Appeal: An oral or written request to **HMO** to reconsider an **adverse determination**.

Complaint: Any oral or written expression of dissatisfaction about quality of care or the operation of the **HMO** plan.

Concurrent Care Claim Extension: A request to extend a previously approved course of treatment or provide additional services or home health care services following discharge from an inpatient hospital admission.

Expedited Appeal: **Appeal** of an **adverse determination** involving (1) continued or extended services, procedures and treatments or additional services for a **Member** undergoing a course of continued treatment prescribed by a **Health Care Provider** or home health care or rehabilitation services following discharge from an inpatient hospital admission, or (2) an **adverse determination** in which the **health care provider** believes an immediate **appeal** is warranted, except any retrospective determination, or (3) for an **adverse determination** involving an **urgent care claim.**

Grievance: A request for review of a determination, other than a determination meeting the definition of **adverse determination**.

Health Care Provider: A health care professional or a facility licensed pursuant to NY law.

Pre-service Claim: Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

Post-Service Claim: Any claim that is not a "**Concurrent Care Claim Extension**," an "**Urgent Care Claim**" or a “**Pre-Service Claim**.”

Urgent Care Claim: Any claim for medical care or treatment with respect to which a delay: (a) could seriously jeopardize the life or health of the **Member** or the ability of the **Member** to regain maximum function; or (b) in the

opinion of a **Physician** with knowledge of the **Member's** medical condition would subject the **Member** to severe pain that cannot be adequately managed without the requested treatment.

Rare Disease: A life threatening or disabling condition or disease that: (1) (a) is currently or has been subject to a research study by the National Institutes of Health **Rare Disease**s Clinical Research Network; or (b) affects fewer than 200,000 United States residents per year; and (2) for which there does not exist a standard health service or procedure covered by **HMO** that is more clinically beneficial than the requested health service or treatment.

Claim Determinations

Pre-Service Claims
HMO will make notification of a claim determination as soon as possible but not later than 3 business days after receipt of the claim. In the event **Member** fails to provide all of the necessary information for **HMO** to make a claim determination, **HMO** will request such information within 3 days of receipt of the claim and will allow the **Member** 45 days to submit the necessary information. **HMO** will make a claim determination within 3 business days after receipt of such information. If the information requested is not received by **HMO** after 45 days, **HMO** will make a determination based on information available and will notify **Member** of the decision within 15 days. **HMO** will notify **Member,** or **Member's** designee, and **Member's health care provider** of the determination by telephone and in writing. Notification will include the total of approved services, the date of the onset of services and the next review date.

With respect to **Pre-Service Urgent Care Claims**, **HMO** will make a notification by telephone and in writing within 24 hours after receipt of the claim. If more information is needed, Aetna will request it within 24 hours. The **Member**, the **Member's** designee and the **Member's Health Care Provider** will have 48 hours to submit the needed information. **HMO** will make a determination and provide notice to you or your designee and your **Health Care Provider** by telephone and in writing within 48 hours of the earlier of **HMO's** receipt of the information or the end of the 48 hour period after **HMO's** request of the information.

Concurrent Care Claim Extension
Following a request for a **concurrent care claim extension**, **HMO** will make notification of a claim determination by telephone and in writing to **Member**, **Member's** designee and **Member's health care provider** as soon as possible, but no later than 24 hours after receipt of the necessary information. With respect to home health care services following an inpatient hospital admission, **HMO** will make the notification no later than 72 hours after receipt of the necessary information when the day of the request falls on a weekend or a holiday. But, coverage shall not be denied on the basis of medical necessity or lack of authorization while the decision is pending.

With respect to **Concurrent Claims** that involve urgent matters, **HMO** will make a determination and will notify the **Member**, the **Member's** designee and the **Member's Health Care Provider** by telephone and in writing within 24 hours after receipt of the request, if the request for additional information is made at least 24 hours prior to the end of the period for which benefits have been approved. Requests that are not made within this time will be determined within the timeframes for **Pre Service Urgent Care Claims**. If **HMO** has approved a course of treatment, **HMO** will not reduce or terminate the approved services before giving the **Member** enough prior notice of the reduction or termination so that the **Member** can complete the **appeal** process before the services are reduced or terminated.

Post-service Claims
HMO will make notification of a claim determination in writing as soon as possible but not later than 30 calendar days after receipt of the claim. In the event **Member** fails to provide all of the necessary information for **HMO** to make a claim determination, **HMO** will allow **Member** 45 days to submit the necessary information, and will make a claim determination within 15 days after receipt of such information. If the information requested is not received by **HMO** after 45 days, **HMO** will make a determination based on information available and will notify **Member** of the decision within 15 days.

The Notice of **adverse determination** will include:

- The reasons for the **adverse determination**, including reference to specific plan provisions upon which the determination is based and the clinical rationale, if any;
- A description of the **HMO's** review procedures, including a statement of claimants' rights to bring a civil action
- Instructions on how to start the **appeals**, **expedited appeals** and external **appeals** process;
- Notice of the availability, upon request, of the clinical review criteria used to make the **adverse determination**. This notice will also specify what necessary additional information, if any, must be provided to, or obtained by, **HMO** in order to render a decision on **appeal**.

In the event that **HMO** renders an **adverse determination** without first attempting to discuss the matter with the **Member's Health Care Provider** who specifically recommended the service, the **health care provider** will have the opportunity to request a reconsideration of the **adverse determination**. Except for **post-service claim**s, such reconsideration will occur within one business day of receipt by **HMO** of the request. If the **adverse determination** is upheld, **HMO** will provide notice, as described above.

If **HMO** does not render a decision within the period set forth above, **Member** may consider this to be an **adverse determination**, subject to **appeal**.

Complaints

If the **Member** is dissatisfied with the service he or she receives from **HMO** or wants to complain about a **Health Care Provider**, **Member** must call or write **Member** Services. The **Member** must include a detailed description of the matter and include copies of any records or documents that **Member** thinks are relevant to the matter. **HMO** will review the information and provide **Member** with a written response within 15 calendar days of the receipt of the **complaint**, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell **Member** what he or she needs to do to seek an additional review.

The **Member** Services telephone number is on the **Member's** ID card. If **Member** is required to leave a recorded message, the message will be acknowledged within one business day after the call was recorded.

For written **complaint**s, an acknowledgement letter will be sent to **Member** within 15 days of **HMO's** receipt of the **complaint**. This letter may request additional information. If so, the additional information must be submitted to **HMO** within 15 days of the date of the letter.

Appeals of Adverse Determinations

Member may submit an **appeal** if **HMO** gives notice of an **adverse determination**. **HMO** provides for two levels of **appeal**. It will also provide an option to request an external review of the **adverse determination.**

The **Member** has 180 calendar days following the receipt of notice of an **adverse determination** to request the level one **appeal**. The **appeal** may be submitted orally or in writing. The request should include:

Member's name;
Member's employer's name;
A statement from **Member's Health Care Provider**;
A copy of **HMO's** notice of an **adverse determination**;
Member's reasons for making the **appeal**; and
Any other information **Member** would like to have considered.

The Notice will be sent to you, your designee and your Health Care Provider.

The **Member** should send the **appeal** to **Member** Services at the address shown on **Member's** ID Card, or call in the **appeal** to **Member** Services, using the toll-free telephone number shown on the ID Card.

The **Member** may also choose to have an authorized designee make the **appeal** on his or her behalf by providing written consent to **HMO**. **Member's Health Care Provider** may make the **appeal** in connection with the **adverse determinatio**n for a **post service claim**.

Level One Appeal

A level one **appeal** of an **adverse determination** shall be decided by **HMO** personnel not involved in making the **adverse determination**.

Expedited Appeals
HMO has established an **expedited appeals** process for **adverse determinations** involving **urgent care claim**s, **concurrent care claim extensions** and **pre-service claims**. **HMO** will render a decision involving **urgent care, concurrent claim extension** and **pre-service claims** within the earlier of 72 hours of receipt of the **appeal** or 2 business days from receipt of the necessary information to conduct the **appeal**.

Pre-Service Claims (other than those subject to an **Expedited Appeal**)
HMO shall issue a decision within 15 days of receipt of the **appeal**.

Post-Service Claims
HMO shall issue a decision within the earlier of 15 days of receipt of the necessary information to conduct the **appeal** or 30 days of receipt of the request for an **appeal**.

The notice of the **appeal** determination will include:

- If the **adverse determination** is upheld, the reason for the determination, including the clinical rationale for it; and
- A notice of **Member's** right to an external **appeal**, together with information and a description of the external **appeals** process. **Member** also has the option to request a Level 2 **appea**l from **HMO**.

If **HMO** does not render an **appeal** determination for a Standard or **Expedited appeal** within the timeframes set forth above, the **adverse determination** will be reversed.

Level Two Appeal

If **HMO** upholds an **adverse determination** at the first level of **appeal**, **Member** or **Member's** authorized representative has the option to file a level two **appeal**, or request an External **Appeal**. The Level Two **appeal**, if requested, must be submitted within 60 calendar days following the receipt of notice of a level one **appeal** determination**.** Please note that if the **Member** decides to pursue a Level Two **appeal** and wait for a decision from Aetna, the **Member** may miss the deadline to request an External **Appeal** from the New York State Insurance Department. Also, the **Member** may wish to end the Level Two **appeal** once the **Member** receives notice from the New York State Insurance Department that the request for an External **Appeal** has been received and is being sent out for review.

A level two **appeal** of an **adverse determination** of an **expedited appeal** shall be decided by **HMO** personnel not involved in making the **adverse determination**. A level two **appeal** of an **adverse determination** of a **pre-service claim** or a **post-service claim** will be reviewed by the **HMO's Appeal**s Committee.

Expedited Appeals (Urgent Care Claims, Concurrent Care Claims Extensions and Pre-Service Claims)
HMO shall issue a decision within 24 hours of receipt of the request for a level two **appeal** for these claims.

Pre-Service Claims (other than those subject to an **Expedited Appeal**)
HMO shall issue a decision within 15 calendar days of receipt of the request for level two **appeal**.

Post-Service Claims
HMO shall issue a decision within 30 calendar days of receipt of the request for a level two **appeal**.

Grievances

You may submit a **grievance** to Aetna with respect to review of any determination other than an **adverse benefit determination**. The **grievance** must be submitted not less than 60 business days after receipt of the notice of the determination.

The **HMO** will acknowledge receipt of the **grievance** within 15 calendar days after its receipt by the **HMO**.

A **grievance** may be submitted if coverage is being rescinded pursuant to the "Termination for Cause" subsection of the **Certificate**. In that case, **HMO** will continue the **Member**'s coverage until a final decision on the **grievance** is rendered, provided the **Premium** is paid through the period prior to the issuance of such final decision. **HMO** may rescind coverage, to the date coverage would have terminated had the **Member** not submitted the **grievance** to **HMO**, if the final decision is in favor of **HMO**. If coverage is rescinded, **HMO** will provide the **Member** with a 30 day advance written notice prior to the date of the rescission, and refund any **Premiums** paid for any period after the termination date, minus the cost of **Covered Benefits** provided to the **Member** during this period.

The **grievance** process for rescissions described above applies only to those terminations affected pursuant to the "Termination for Cause" subsection of the **Certificate**.

Grievance Determinations
Expedited **Grievance**s
HMO will resolve an expedited **grievance** within the lesser of 48 hours from receipt of the necessary information or 72 hours from receipt of the **grievance** when delay would significantly increase the risk to a **Member's** health.

Standard **Grievance**s
For other **grievances**, **HMO** will resolve the **grievance** within the lesser of 30 days from receipt of the necessary information or 15 days from receipt of the **grievance** for **pre-service claim**s **grievances**, or 30 days after receipt of a post service claims **grievance**.

Grievance Appeals
Expedited **Grievance**s
HMO will render a decision within 36 hours after receipt of the **appeal**.

Standard **Grievance**s
For other **grievances, HMO** will render a decision within 15 days from the receipt of the **grievance appeal** for **pre-service claim**s **grievances** and within 30 days from receipt of the **grievance appeal** for post service claims **grievances.**

External Review

Right to an External Appeal

Under certain circumstances, the **Member** has a right to an external **appeal** of a denial of coverage. Specifically, if **HMO** has denied coverage on the basis that the (a) service is not **Medically Necessary** or is an **Experimental or Investigational Procedure**, or (b) such service is provided and an alternate is available under the **HMO Certificate**, the **Member** may **Appeal** that decision to an External **Appeal** Agent, an independent entity certified by the State to conduct such **appeal**s.

Right to Appeal a Determination that a Service is not Medically Necessary

If the **HMO** has denied coverage on the basis that the service is not **Medically Necessary,** the **Member** may **appeal** to an External **Appeal** Agent if **Member** satisfies the following criteria listed below:

- The service must otherwise be a **Covered Service** under this **Certificate**; and

- The **Member** must have received a final **adverse determination** through the first level of **HMO's** internal review process and the **HMO** must have upheld the denial or the **Member** and the **HMO** must agree in writing to waive any internal **appeal**.

Right to Appeal a Determination that a Service is Experimental or Investigational

If a **Member** has been denied coverage on the basis that the service is an **Experimental or Investigational Procedure**, the **Member** must satisfy the following criteria:

- The service must otherwise be a **Covered Service** under this **Certificate**; and
- The **Member** must have received a final **adverse determination** through the first level of the **HMO's** internal **appeal** process and **HMO** must have upheld the denial or the **Member** and **HMO** must agree in writing to waive any internal **appeal**.

In addition, the **Member's** attending **Physician** must certify that the **Member** has a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one which, according to the current diagnosis of the attending **Physician**, has a high probability of death. A "disabling condition or disease" is any medically determinable physical or medical impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months, which renders the **Member** unable to engage in any substantial gainful activities. In the case of a dependent child under the age of 18, a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

The **Member's** attending **Physician** must also certify that the life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered under this **Certificate** or one for which there exists a clinical trial (as defined by law) or **rare disease** treatment. In the case of a **rare disease**, the attending **Physician** may not be the treating **Physician**.

The **Member**'s attending **Physician** must be a licensed, board certified or board eligible physician qualified to practice in the area of practice appropriate to treat the **Member**'s life threatening or disabling condition.

In addition, the **Member's** attending **Physician** must have recommended at least one of the following:
- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to the **Member** than any standard **Covered Service** (only certain documents will be considered in support of this recommendation – the **Member's** attending **Physician** should contact the State in order to obtain current information as to what documents will be considered acceptable) or in the case of a **rare disease**, based on the **Physician's** certification and such other evidence as the **Member**, the **Member's** designee or the **Member's** attending **Physician** may present; or
- A clinical trial for which the **Member** is eligible (only certain clinical trials can be considered).

Right to **Appeal** a Determination that an Alternate Service is available under **HMO Certificate**.

If coverage for (other than a clinical trial, which is covered immediately above), has been denied on **appeal** on the basis that an alternate service is available under the **HMO Certificate, Member** may **appeal** to an External **Appeal** Agent if **Member** satisfies the following criteria listed below:
- The service, procedure or treatment must otherwise be a **Covered Service** under **HMO**; and
- **Member** must have received a final **adverse determination** through the first level of **HMO's** internal review process and **HMO** must have upheld the denial, or **Member** and **HMO** must agree in writing to waive any internal **appeal**.
- The attending **Physician** certifies that such service is (i) materially different than the alternate service under the **HMO Certificate**; and (ii) based on two documents from available medical and scientific evidence, such service is likely to be more clinically beneficial than the alternate service under the **HMO Certificate** and the adverse risk would not be substantially increased.

For the purposes of this section, the **Member's** attending **Physician** must be a licensed, board certified or board eligible **Physician** qualified to practice in the area appropriate to treat the **Member's** life-threatening or disabling

condition or disease, or **Rare Disease**. In the case of a **rare disease**, the attending **Physician** may not be the treating **Physician**.

The External Appeal Process

If, through the first level of **HMO's** internal **appeal** process, the **Member** has received a final **adverse determination** upholding a denial of coverage on the basis that the service is not **Medically Necessary** or is an **Experimental or Investigational Procedure**, or an alternate service is available, **Member** has 45 days from receipt of such notice to file a written request for an external **appeal**. If **Member** and **HMO** have agreed to waive any internal **appeal**, the **Member** has 45 days from the receipt of such waiver to file a written request for an external **appeal**. **HMO** will provide an external **appeal** application with the final **adverse determination** issued through the first level of **HMO's** internal **appeal** process or its written waiver of an internal **appea**l.

The **Member** may also request an external **appeal** application from the New York State Department of Insurance at 1-800-400-8882, or from the New York State Department of Health at 1-800-206-8125, or by mail at New York State Department of Health, Division of Managed Care, Bureau of Managed Care Certification and Surveillance, Empire State Plaza, Corning Tower, Room 1911, Albany, New York 12237-0062. The **Member** shall submit the completed application to the New York State Department of Insurance at the address listed in the application. If **Member** satisfies the criteria for an external **appeal**, the State will forward the request to a certified External **Appeal** Agent. The **Member** will have the opportunity to submit additional documentation with the request. If the External **Appeal** Agent determines that the information **Member** submits represents a material change from the information on which **HMO** based its denial, the External **Appeal** Agent will share this information with **HMO** in order for it to exercise its right to reconsider its decision. If **HMO** chooses to exercise this right, **HMO** will have three (3) business days to amend or confirm its decision. Please note that in the case of an **expedited appeal** (described below), **HMO** does not have a right to reconsider its decision.

In general, the External **Appeal** Agent must make a decision within thirty (30) days of receipt of the completed application. The External **Appeal** Agent may request additional information from the **Member**, the **Member's Physician or Health Care Provider** or the **HMO**. If the External **Appeal** Agent requests additional information, it will have five (5) additional business days to make its decision. The External **Appeal** Agent must notify the **Member**, or the **Member's Physician**, where appropriate, in writing of its decision within two (2) business days.

If the **Member's** attending **Physician or Health Care Provider** certifies that a delay in providing the service that has been denied poses an imminent or serious threat to the **Member's** health, the **Member** may request an expedited external **appeal**. In that case, the External **Appeal** Agent must make a decision within three (3) days of receipt of the completed application. Immediately after reaching a decision, the External **Appeal** Agent must try to notify the **Member** and **HMO** by telephone or facsimile of that decision. The External **Appeal** Agent must also notify the **Member** in writing of its decision.

If the External **Appeal** Agent overturns **HMO's** decision that a service is not **Medically Necessary** or approves coverage of an **Experimental or Investigational Procedure**, or determines that the service should be covered under the **HMO Certificate**, the **HMO** will provide coverage subject to the other terms and conditions of this **Certificate**. If the External **Appeal** Agent approves coverage of an **Experimental or Investigational Procedure** that is part of a clinical trial, **HMO** will only cover the costs of services required to provide treatment to **Member** according to the design of the trial. **HMO** shall not be responsible for the costs of investigational drugs or devices; the costs of non-health care services; the costs of managing research; or costs which would not be covered under this **Certificate** for non-experimental or non-investigational procedures provided in such clinical trial.

The External **Appeal** Agent's decision is binding on both the **Member** and **HMO**. The External **Appeal** Agent's decision is admissible in any court proceeding.

A **Physician** or **Health Care Provider** requesting an external **appeal** of an adverse claim determination involving a **concurrent care claim**, including when such **Physician** or **Health Care Provider** requests the external **appeal** as the **Member'**s designee, shall not pursue reimbursement from any **Member** for services determined not **Medically Necessary** by the External **Appeal**s Agent, except to collect a copayment.

Member's Responsibilities

Except as provided below under "**Appeal**s of Admissions for or Provision or Continuation of Access to End of Life Care for **Members** Diagnosed with Advanced Cancer", it is the **Member's** responsibility to initiate the external **appeals** process. **Member** may initiate the external **appeal** process by filing a completed External **Appeal** application with the New York State Department of Insurance. The **Member** may designate an authorized representative at any time to pursue an external **appeal**. The **Member**, or **Member's** designee, may file an external **appeal** application; but if it's filed by **Member's** designee, **Member** must consent to it in writing. The Department of Insurance may request from **Member** written confirmation of the appointment of a designee. In addition, **Member's** attending **Physician or Health Care Provider** has the right to pursue an external **appeal** of a concurrent or retrospective **adverse claim determination**. To do so, the attending **Physician or Health Care Provider** must complete an External **Appeal** application for **health care provider**s. **Member** must sign an acknowledgment of the request and a consent to release of any medical records.

Under New York State law, the completed request for **appeal** must be filed within 45 days of either: the date upon which **Member** receives written notification from **HMO** that it has upheld a denial of coverage; or the date upon which **Member** receives a written waiver of any internal **appea**l. **HMO** has no authority to grant an extension of this deadline.

Covered Services and Exclusions

In general, this **Certificate** does not cover **Experimental or Investigational Procedures**. However, this **Certificate** shall cover an **Experimental or Investigational Procedure** approved by an External **Appeal** Agent in accordance with this section. If the External **Appeal** Agent approves coverage of an **Experimental or Investigational Procedure** that is part of a clinical trial, **HMO** will only cover the costs of services required to provide treatment to you according to the design of the trial. **HMO** shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this **Certificate** for non-experimental or non-investigational procedures provided in such clinical trial.

APPEALS OF ADMISSIONS FOR OR PROVISIONS OR CONTINUATION OF ACCESS TO END OF LIFE CARE FOR MEMBERS DIAGNOSED WITH ADVANCED CANCER

The following applies if a **Member**: (i) has been diagnosed with advanced cancer (with no hope of reversal of primary disease and fewer than 60 days to live, as certified by the **Member's Physician**); and (ii) the **Physician**, in consultation with the medical director of a facility specializing in the treatment of terminally ill patients and licensed pursuant to article 28 of the public health law, has determined that the **Member's** care would be appropriately provided by such facility.

In the event **HMO** disagrees with the admission of or provision or continuation of care of the **Member** by the facility, **HMO** must initiate an expedited external **appeal** as described above. However, until a decision is rendered, such admission for, provision of or continuation of the care by the facility will not be denied, and **HMO** will continue to provide such coverage. The decision of the external **appeal**s agent will be binding on all parties.

HMO will keep records of **Member's** complaint for 7 years.

AETNA HEALTH INC.
(NEW YORK)

AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

1. The "**Dependent Eligibility"** section, appearing in the **Schedule of Benefits**, forming a part of the **Certificate**, is replaced by the following.

Dependent Eligibility: A dependent unmarried child of the **Subscriber** as described in the Eligibility and Enrollment section of the **Certificate,** who is under 30 years of age.

2. The following section **"New York Continuation Rights of HMO Coverage for Unmarried Young Adults through Age 29"** is added to the **Certificate:**

New York Continuation Rights of HMO Coverage for Unmarried Young Adults through Age 29

Eligibility

Young adult means: a child of the **Subscriber** who (a) is age 29 or younger; (b) is not married; (c) is not covered, or eligible for coverage, under his or her employer-sponsored group health benefits plan; (5) lives, works or resides in New York State or in **HMO's Service Area**; (6) is not covered under Medicare.

To be eligible for coverage, the young adult need not live with the **Subscriber**, or be financially dependent on the **Subscriber** for support and maintenance, or be enrolled in an educational institution, or be covered as a **Subscriber's** dependent under the plan.

Coverage

This applies to: (1) a young adult who has ceased to be eligible for **HMO** coverage under this **Certificate** as a result of his or her attainment of an age limit; or (2) a young adult who is eligible for dependents coverage, but not covered, under the **HMO** plan. Such a person will have the option to continue **HMO** coverage. Either the young adult or the **Subscriber** may make the election to continue **HMO** coverage in writing and pay the first **Premium** within 60 days of the young adult's date of eligibility, and on a monthly basis thereafter, to the **Contract Holder**. "**HMO** coverage" means coverage under this **Certificate**.

The continued **HMO** coverage shall be identical to the coverage provided to the **Subscriber** under this **Certificate**, and is subject to the same terms and conditions that apply to the **Subscriber's** coverage.

Conditions for Continuation

The young adult, or the **Subscriber**, must request this continuation option in writing as follows:

Within 60 days after the young adult's loss of **HMO** coverage on account of attainment of a limiting age - The young adult or the **Subscriber** may elect this continuation option within 60 days of the date on which the young adult would otherwise lose eligibility for coverage under the **Subscriber's** plan on account of his or her attainment of the limiting age for dependent children. If the option is elected within the 60 days, coverage will be retroactive to the date as of which the dependent's coverage ended.

Within 60 days after becoming eligible for this option due to a change in the young adult's personal circumstances - The young adult or the **Subscriber** may elect this continuation option within 60 days of the date on which the young adult becomes eligible for continuation due to a change in his or her personal circumstances (such a change of residence to New York State, or becoming divorced).

During the Annual **Open Enrollment Period** - A young adult or the **Subscriber** may elect this continuation option during the annual **Open Enrollment Period**.

During the Initial **Open Enrollment Period** - A young adult or the **Subscriber** may elect this continuation option during the initial **Open Enrollment Period**, which runs for 12 months following the first renewal of the **Group Agreement** coinciding with or next following September 1, 2009.

Termination of Coverage

The **HMO** continuation of coverage for the young adult shall terminate upon the first to occur of:

- The date the young adult is no longer eligible for coverage continuation;
- The date on which the **Subscriber's** coverage ends;
- The end of the period for which required premium has been paid, if **Premium** payment is not made within the grace period; or
- The date as of which the **Group Agreement** terminates.

AETNA HEALTH INC.
(NEW YORK)

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 provided a written statement declining coverage under the **HMO** because the eligible individual or dependent had such other coverage, but only if such written statement is required by the employer, the employer gives written notice to the eligible individual or dependent of this requirement and the notice explains the consequences of the failure on the part of the eligible individual or dependent to provide such written statement;

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
- exhaustion of any individual overall maximum benefit under the medical plan;
- termination of benefit package.

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

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.
(NEW YORK)

COMPASSIONATE CARE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

1. The **Hospice Care** definition in the Definitions section of the **Certificate Contract** 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. (When providing hospice services, **HMO** will only contract with a Public Health Law, Article 40, hospice agency, or an agency certified by the jurisdiction in which the hospice organization is located).

AETNA HEALTH INC.
(NEW YORK)

MENTAL DISORDERS AND SUBSTANCE USE BENEFITS AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

1. The definition of **Mental or Behavioral Condition** shown in the **Definitions** section of the **Certificate** is deleted.

2. The section **Mental Health Benefits** of the **Certificate** is replaced by the following:

- **Mental Health Benefits.**

  A **Member** is covered for services for the treatment of the following **Mental Disorders** and for **Children with Serious Emotional Disturbances** through **Participating Behavioral Health Providers**.

  Treatment of **Mental Disorders** means: **Medically Necessary** care rendered by an eligible practitioner or approved facility and which, in the opinion of **HMO**, is directed predominantly at treatable behavioral manifestations of a condition that **HMO** determines (a) is a clinically significant behavioral or psychological syndrome, pattern, illness or disorder; and (b) substantially or materially impairs a **Member's** ability to function in one or more life activities; and (c) has been classified as a **Mental Disorder** in the current American Psychiatric Diagnostic and Statistical Manual of Mental Disorders.

  The following conditions are considered a Mental Disorder under this Certificate:

  Biologically-based Mental Illnesses - defined as:
  Schizophrenia/psychotic disorders
  Major depression
  Bipolar disorder
  Delusional disorders
  Panic disorder
  Obsessive compulsive disorders
  Bulimia
  Anorexia

  Non-Biologically-based Mental Illnesses

  Children with Serious Emotional Disturbances means: persons under the age of eighteen years who have diagnoses of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders, and where there are one or more of the following:

  - Serious suicidal symptoms or other life-threatening self-destructive behaviors;
  - Significant psychotic symptoms (hallucinations, delusion, bizarre behaviors);
  - Behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or

- Behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household.

Coverage for the treatment of **Mental Disorders** and for **Children with Serious Emotional Disturbances** is provided through **Participating Behavioral Health Providers**, as follows:

1. Outpatient benefits for services rendered by a facility issued an operating certificate by the commissioner of mental health, a facility operated by the office of mental health, a licensed psychiatrist or psychologist, a licensed clinical social worker, or a professional corporation or university faculty practice corporation are covered on the same basis as for any other medical condition.

2. Inpatient benefits may be covered for medical, nursing, counseling or therapeutic services in an inpatient **Hospital,** as defined in the mental hygiene law, or a non-hospital residential facility appropriately licensed by the Department of Health or its equivalent. Coverage is provided on the same basis as for any other medical condition. When authorized by **HMO**, one inpatient hospitalization day may be exchanged for 2 partial hospitalization visits.

3. The section **Substance Abuse Benefits** of the **Certificate** is replaced by the following:

- **Substance Use Benefits.**

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

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

   Member is entitled to outpatient visits to a **Participating Behavioral Health Provider** upon **Referral** by the **PCP** for diagnostic, medical or therapeutic **Substance Use Rehabilitation** services.

2. Inpatient care benefits are covered for **Detoxification**. Benefits include medical treatment and referral services for **Substance Use** 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.

3. **Member** is entitled to medical, nursing, counseling or therapeutic **Substance Use Rehabilitation** services in an inpatient, **Hospital** or non-hospital **Residential Treatment Facility**, which is certified by the office of alcoholism and substance abuse services, or equivalent in states other than New York, upon referral by the **Member's Participating Behavioral Health Provider** for alcohol or drug use or dependency.

4. The **Outpatient Benefits** section of the Schedule of Benefits forming part of the **Certificate** is modified as follows:

The Section **Outpatient Mental Health Visits** is replaced by the following:

Outpatient Mental Health Visits

Benefit	**Copayment**
Coverage for **Mental Disorders** and for **Children with Serious Emotional Disturbances**.	**$10 per visit/day**

The Section **Outpatient Substance Abuse Visits** is replaced by the following:

Outpatient Substance Use Visits

Benefit	**Copayment**
Detoxification	**$10 per visit/day**
Rehabilitation	**$10 per visit/day**

5. The **Inpatient Benefits** section of the Schedule of Benefits forming part of the **Certificate** is modified as follows:

The Section **Mental Health** is replaced by the following:

Mental Health

Benefit	**Copayment**
Coverage for **Mental Disorders** and for **Children with Serious Emotional Disturbances**.	Coverage is provided on the same basis as for any other medical condition.

The Section **Substance Abuse** is replaced by the following:

Substance Use

Benefit	**Copayment**
Detoxification	Coverage is provided on the same basis as any other medical condition.
Rehabilitation	Coverage is provided on the same basis as any other medical condition.

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

AETNA HEALTH INC.
(NEW YORK)

CERTIFICATE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The section "Claim Procedures" is replaced by the following:

CLAIM PROCEDURES

A claim occurs whenever a **Member** or the **Member's** authorized representative requests pre-authorization as required by the plan from **HMO**, a **Referral** as required by the plan from a **Participating Provider** or requests payment for services or treatment received. As an **HMO Member**, most claims do not require forms to be submitted. However, if a **Member** receives a bill for **Covered Benefits**, the bill must be submitted promptly to the **HMO** for payment. Send the itemized bill for payment with the **Member's** identification number clearly marked to the address shown on the **Member's** ID card. Benefits will be paid promptly after the receipt by **HMO**, but in no event later than (a) 30 days of receipt of a claim transmitted electronically or via the internet; or (b) 45 days for a claim submitted by other means.

AETNA HEALTH INSURANCE COMPANY OF NEW YORK
(NEW YORK)

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.
(NEW YORK)

AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

1. The second paragraph of Subsection **Injectible Medications Benefit**, of the **Certificate**, is replaced by the following:

   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 following established reference compendia: the American Hospital Formulary Service - Drug Information (AHFSDI); the National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex Drugdex; Elsevier Gold Standard's Clinical Pharmacology or other authoritative compendia as identified by the federal Secretary of Health and Human Services or the Centers for Medicare & Medicaid; or recommended by review article or editorial comments in a major peer reviewed professional journal.

2. Section C of **"Covered Benefits"** of the Prescription Drug Rider is replaced by the following:

   C. FDA approved prescription drugs are covered when the off-label use of the drug has not been approved by the FDA for that indication, provided that such drug is recognized for treatment of such indication in one of the following established reference compendia: the American Hospital Formulary Service - Drug Information (AHFSDI); the National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex Drugdex; Elsevier Gold Standard's Clinical Pharmacology or other authoritative compendia as identified by the federal Secretary of Health and Human Services or the Centers for Medicare & Medicaid; or recommended by review article or editorial comments in a major peer reviewed professional journal. Coverage of off label use of these drugs may be subject to **Precertification Program** , the **Step Therapy Program,** or other **HMO** requirements or limitations. Subsequent to the final determination of the external review process, experimental or investigational drugs will be covered, as required.

AETNA HEALTH INC.
(NEW YORK)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

Important Disclosure Information

We want you to know®

Aetna®

Aetna Health Network Only SM, HMO, Open Access® HMO, Aetna Health Network Option SM, QPOS® and Aetna Choice® POS Plans.

The following information supplements information you will find in this Aetna Health Inc. Certificate of Coverage (as to Referred Benefits) and the Aetna Health Insurance Company of New York (Self-referred Benefits) Certificate of Coverage.

State mandates do not apply to self-funded plans governed by ERISA. If you are unsure if your plan is self-funded and/or governed by ERISA, please confer with your benefits administrator. Specific plan documents supersede general disclosures contained within, as applicable.

General Information
Your plan of benefits will be determined by your plan sponsor while the plan itself is underwritten or administered by Aetna Health Inc. 333 Earle Ovington Boulevard, Suite 104, Uniondale, New York 11553. You may contact us at this address or by contacting our Member Services Unit at 1-888-982-3892.

Member Services and Aetna Navigator Member Website
When you require assistance from an Aetna representative, call us during regular business hours at the number on your ID card or e-mail us at **www.aetna.com**. You may also access your plan information from our secure member website at Aetna Navigator.

To access Aetna Navigator, Click on "Aetna Navigator",
Enter your user name and password and click "Go". If you are not a member yet, click on "Members: Secure Information" and then "Take a Site Tour" to learn more.

Aetna Navigator allows you to:
- check a claim payment
- compare hospitals in your area or anywhere in the country
- obtain medical costs and prescription prices
- obtain healthy lifestyle information
- obtain health information from Harvard Medical School
- look through our online encyclopedia for information about hundreds of health conditions.

For on line member services, Click on "Contact Us" after you log in. Our representatives can:
- Verify or change personal information about your coverage

- Answer benefits questions
- Help you locate network providers
- Find care outside your area
- Advise you how to file a claim or check on a claim payment
- Advise you on how to file complaints and appeals
- Connect you to behavioral health services (if included in your plan)
- Find specific health information
- Provide information on our Quality Management program, which evaluates the ongoing quality of our services

Interpreter Services
Aetna provides a multilingual hotline with interpreters. Call the Multilingual hotline at *1-888-982-3862 (140 languages are available)* You must ask for an interpreter.

Spanish-speaking hotline — 1-800-533-6615

Si usted necesita este documento en otro idioma, por favor llame a Servicios al Miembro al 1-888-982-3862.

Aetna provides information in many languages. **If you need this material translated into another language, please call Member Services at 1-888-982-3862.**

Hearing Impaired
Aetna provides a special toll free contact number for the hearing impaired.

TDD 1-800-628-3323

Plan of Benefits
Covered services include most types of treatment provided by primary care physicians, specialists and hospitals. However, the health plan does exclude and/or include limits on coverage for some services. In addition, in order to be covered, all services, including the location (type of facility), duration and costs of services, must be medically necessary as defined below and as determined by Aetna. The information that follows provides general information regarding Aetna health plans. For a complete description of the benefits available to you, including procedures, exclusions and limitations, refer to your specific plan documents, which may include the Group Agreement, Group Insurance Certificate, Group Policy and any applicable riders and amendments to your plan.

General Conditions for Coverage
The service or supply must be covered by the plan. For a service or supply to be covered, it must: be included as a covered expense in your plan documents and not be an excluded expense and not exceed the maximums and limitations outlined in your plan documents; and be obtained in accordance with all the terms, policies and procedures outlined in your plan documents. The plan will pay for covered medical expenses, up to the maximums shown in your Certificate of Coverage. You are responsible for any expenses incurred over the maximum limits or any non-covered health care procedures treatments or services as outlined in your Certificate of Coverage.

Medically Necessary
"Medically necessary" means that the service or supply is provided by a physician or other health care provider exercising prudent clinical judgment for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that provision of the service or supply is:
- In accordance with generally accepted standards of medical practice; and
- Clinically appropriate in accordance with generally accepted standards of medical practice in terms of type, frequency, extent, site and duration, and considered effective for the illness, injury or disease; and
- Not primarily for the convenience of you, or for the physician or other health care provider; and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the illness, injury or disease.

For these purposes "**generally accepted standards of medical practice**" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical

community, or otherwise consistent with physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Important Note

Not every service, supply or prescription drug that fit the definition for medical necessity is covered by the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. For example some benefits are limited to a certain number of days, visits or a dollar maximum. Refer to your *What the Plan Covers and the Summary of Benefits* for the plan limits and maximums.

Accessing Network Health Care Providers with a Referral
To access network benefits, you are required to select a Primary Care Physician (PCP) when you enroll. A PCP may be a general practitioner, family physician, internist, or a pediatrician. Each covered family member may select his or her own PCP. Your PCP provides routine preventive care and will treat you for illness or injury. Your PCP may refer you to network providers or facilities such as specialists and hospitals for other covered services and supplies. The PCP can also order lab tests and x-rays, prescribe medicines or therapies and arrange hospitalization. Except in a Medical Emergency or for certain direct access specialist benefits as described in your Insurance Certificate, only those services which are provided by or referred by your PCP will be covered as a network benefit.

Accessing Out-of-Network Providers and Facilities
If you have a QPOS plan, you may also utilize out-of-network physicians and facilities for covered benefits. Benefits will be paid at the out-of-network level of coverage. Your out-of-pocket costs will generally be higher when you use out-of-network providers. Refer to your Schedule of Benefits to determine your costs. You will need to get approval before receiving certain services. This is called precertification. You will be required to file your own claim forms. **Out-of-network providers have not agreed to accept the negotiated charge and may balance bill you for charges over the amount Aetna pays under the plan.** Aetna will only pay up to the recognized charge.

Member Cost Sharing
You are responsible for any copayments, coinsurance and deductibles for covered services. Copayments obligations are paid directly to the provider or facility at the time the service is rendered. Coinsurance and deductible obligations are paid to the provider or facility once your claim has been processed and you have received an Explanation of Benefits from Aetna. Copayment, coinsurance and deductible amounts are listed in your Plan Documents.

Role of Primary Care Physicians ("PCPs")
You are required to select a PCP who participates in the network. If you do not select one, we will assign you a PCP in your area, based on your zip code. If you wish to choose a different PCP, you may do so at anytime. To find a new doctor in your area, call Member Services at the toll-free number on your member ID card, or visit DocFind®, our online provider directory at www.aetna.com. Through www.aetna.com you can also register for our Aetna Navigator™ self-service website and select the "Change PCP" option. Before selecting a PCP, you should either call Member Services at the number on your ID card or call the doctor's office directly to verify that he/she is accepting new patients.

A PCP may be a general practitioner, family physician, internist, or a pediatrician. Each covered family member may select his or her own PCP. Your PCP will provide primary care as well as coordinate your overall care. You should consult your PCP when you are sick or injured to help determine the care that is needed. Your PCP will issue referrals to participating specialists and facilities for certain services. For some services, your PCP is required to obtain prior authorization from Aetna. Except for those benefits described in the plan documents as direct access benefits, plans with self-referral to participating providers (Aetna Open Access or Aetna Choice POS), plans that include benefits for nonparticipating provider services (Aetna Choice POS or QPOS),or in an emergency, you will need to obtain a referral authorization ("referral") from your PCP before seeking covered non-emergency specialty or hospital care.

Under Aetna Open Access and Aetna Choice POS plans you may directly access participating providers without a PCP referral, subject to the terms and conditions of the plan and cost sharing requirements. Participating providers will be responsible for obtaining any required preauthorization of services from Aetna.

Find A Doctor
You can search Aetna's online directory DocFind by logging on to Aetna's website at **www.aetna.com**. You can search DocFind for names and locations of physicians and other health care providers and facilities. You can look for a doctor by specialty and location. All the information is here, plus maps and directions to the doctor's office. You can even look for doctors who are board certified, speak your language, and who are accepting new patients. The on-line directory is updated weekly and contains the most current list of network providers.

If you need a printed directory, call Member services at the toll-free number on your ID card. If you are not an Aetna member yet, or if you have not received your ID card call 1-888-87-Aetna (1-888-872-3862). If you use the printed directory, you should call member services or the provider to verify the provider is accepting new patients. Your employer also has copies of provider directories for your reference.

Aetna cannot guarantee the availability or continued participation of a particular provider. Either Aetna or any network provider may terminate the provider contract or limit the number of people accepted in a practice. If the physician initially selected cannot accept additional patients, you will be notified and given an opportunity to make another selection.

How To Change Your PCP or Specialist
You may change your PCP or specialist at any time on Aetna's website, www.aetna.com, or by calling the Member Services toll-free number on your identification card. The change will become effective upon Aetna's receipt and approval of the request.

How Referrals Work
Except for PCP, direct access and emergency or urgent care services, you must have a prior written or electronic referral from your PCP to receive the Plan's network level of coverage for all services and any necessary follow-up treatment. The referral will be good for 90 days, as long as you remain covered under the plan.

- When you visit the provider or facility, bring the referral (or check in advance to verify that they've received the electronic referral). Without it, you'll receive out-of-network coverage – even if you receive your treatment from a network provider.
- Certain services such as inpatient stays, outpatient surgery and certain other medical procedures and tests require both a PCP referral *and* precertification. Precertification verifies that the recommended treatment is covered by Aetna. Your PCP or other network providers are responsible for obtaining precertification for you for in-network services.

Out of Network Referrals for HMO Plans
If a service you need isn't available from a network provider or facility your PCP may refer you to an out-of-network provider. Your PCP or other network provider must get pre-approval from Aetna and issue a special non-participating referral for services from out-of-network providers to be covered at the network level of benefits.

Standing Referrals
If you have a condition which requires ongoing care from a specialist, you may request a standing referral from your PCP or Aetna to such a specialist.

Specialist as PCP
If you have a life-threatening condition or disease or (ii) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, you may request a referral to a specialist with expertise in treating the life-threatening or degenerative and disabling disease or condition who shall be responsible for and capable of providing and coordinating your primary and specialty care. This referral will be issued based on a treatment plan that is approved by Aetna, in consultation with the primary care provider if appropriate, the specialist, and you or your authorized representative.

Direct Specialist Care for life threatening conditions
If you have a life-threatening condition or disease or a degenerative and disabling condition or disease either of which requires specialized medical care over a prolonged period of time, you may request access to a specialty care

center, or a specialist responsible for providing or coordinating your medical care. In order to request these services, please call Member Services at the toll-free number on your ID card or call 1-888-982-3862.

You don't need a PCP referral for:

- Emergency care – See In Case of Medical Emergency.
- Urgent care – See Care for Urgent Medical Conditions.
- Out-of-Network Benefits. The plan gives you the option to visit health care providers and facilities that are not in the provider network without a referral for covered expenses. You may also visit network providers without a referral. You will receive out-of-network coverage for these covered expenses.
- Direct access services – services from network providers for which the referral is not required. Certain routine and preventive services do not require a referral under the plan when accessed in accordance with the age and frequency limitations outlined in the **Covered Benefits** and Schedule of Benefits sections of your Plan documents. Refer to the **Covered Benefits** section for information on when these benefits are covered. You can directly access these network specialists for:
  - Routine gynecologist visits;
  - Routine eye exams in accordance with the schedule;
  - Annual screening mammogram for age-eligible women;
  - Routine Prenatal Care (precertification may be required).
- Under Aetna Choice POS and QPOS plans you may directly access nonparticipating providers without a PCP referral, subject to cost sharing requirements. Even so, you may be able to reduce your out-of-pocket expenses considerably by using participating providers.

Direct Access Ob/Gyn Program

This program allows female members to visit any participating obstetrician or gynecologist for a routine well woman exam, including a Pap smear, and for obstetric or gynecologic problems. Obstetricians and gynecologists may also refer a woman directly to other participating providers for covered obstetric or gynecologic services. All health plan preauthorization and coordination requirements continue to apply. If your Ob/Gyn is part of an Independent Practice Association (IPA), a Physician Medical Group (PMG), an Integrated Delivery System (IDS) or a similar organization, your care must be coordinated through the IPA, the PMG or similar organization and the organization may have different referral policies

Transition of Care

If a Participating Provider leaves the Aetna network, Members who are under an ongoing course of treatment on the day the provider's agreement terminates may continue to receive treatment from the provider during a transitional period of up to ninety days. Female members who have entered the second trimester of pregnancy may continue to receive treatment from the provider for a transitional period that includes the provision of post-partum care directly related to the delivery.

A Member whose health care provider is not a Participating Provider at the time of enrollment may request to continue an ongoing course of treatment with that provider for a period of up to 60 days from the effective date of enrollment if the Member has a life-threatening disease or condition or a degenerative and disabling disease or condition. If the Member has entered the second trimester of pregnancy at the effective date of enrollment, the transitional period shall include post-partum care directly related to the delivery. For such a request for transitional coverage to be approved, the health care provider must agree to accept reimbursement from the HMO at established rates prior to the start of the transitional period as payment in full; adhere to the HMO's quality assurance requirements; provide the HMO with necessary medical information related to this care; and adhere to the HMO's policies and procedures.

In accordance with New York law, transitional care is not permitted if the provider leaves the network due to imminent harm to patient care, a determination of fraud or a final disciplinary action by a state licensing board (or other governmental agency) that impairs the health care professional's ability to practice.

Transplants and Other Complex Conditions

Our National Medical Excellence Program® and other specialty programs help you access covered treatment for transplants and certain other complex medical conditions at participating facilities experienced in performing these

services. Depending on the terms of your plan of benefits, you may be limited to only those facilities participating in these programs when needing a transplant or other complex condition covered.

Emergency Care
If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world. An emergency medical condition means a medical or behavioral condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy; or (2) serious impairment of such person's bodily functions; or (3) serious dysfunction of any bodily organ or part of such person; or (4) serious disfigurement of such person.

Treatment for an emergency medical condition is not subject to prior approval. However, whether you are in or out of an Aetna service area, we simply ask that you follow the guidelines below when you believe you need emergency care.

- Call the local emergency hotline (ex. 911) or go to the nearest emergency facility. If a delay would not be detrimental to your health, call your PCP. Notify your PCP as soon as possible after receiving treatment.
- If you are admitted to an inpatient facility, you or a family member or friend on your behalf should notify your PCP or Aetna as soon as possible.
- Covered Expenses for emergency medical conditions are payable in accordance with your plan. Please refer to your summary of benefits for the applicable copay, deductible and co-insurance amounts that apply.

What to Do Outside Your Aetna Service Area
If you are traveling outside your Aetna service area or if you are a student who is away at school; you are covered for emergency and urgently needed care. Urgent care may be obtained from a private practice physician, a walk-in clinic, an urgent care center or an emergency facility. Certain conditions, such as severe vomiting, earaches, sore throats or fever, are considered “urgent care" outside your Aetna service area and are covered in any of the above settings.

Claims for Emergency Care

If, after reviewing information submitted to us by the provider that supplied care, the nature of the urgent or emergency problem does not qualify for coverage, it may be necessary to provide us with additional information. We will send you an Emergency Room Notification Report to complete, or a Member Services representative can take this information by telephone. However, emergency care expenses that are not related to an emergency medical condition are excluded and are the member’s financial responsibility.

Follow-up Care after Emergencies
All follow-up care should be coordinated by your PCP. Follow-up care with nonparticipating providers is only covered with a referral from your PCP and prior authorization from Aetna. Whether you were treated inside or outside your Aetna service area, you must obtain a referral before any follow-up care can be covered. Suture removal, cast removal, X-rays and clinic and emergency room revisits are some examples of follow-up care.

After-Hours Care
You may call your doctor’s office 24 hours a day, 7 days a week if you have medical questions or concerns. You may also consider visiting participating Urgent Care facilities.

How Aetna Compensates Your Health Care Provider and Other Providers
All the physicians are independent practicing physicians that are neither employed nor exclusively contracted with Aetna. Individual physicians and other providers are in the network by either directly contracting with Aetna and/or affiliating with a group or organization that contract with us.

Participating providers in our network are compensated in various ways for the services covered under your plan:

- Per individual service or case (fee for service at contracted rates).
- Per hospital day (per diem contracted rates).
- Capitation (a prepaid amount per member, per month).
- Through Integrated Delivery Systems (IDS), Independent Practice Associations (IPA), Physician Hospital Organizations (PHO), Physician Medical Groups (PMG), behavioral health organizations and similar provider organizations or groups. Aetna pays these organizations, which in turn may reimburse the physician, provider organization or facility directly or indirectly for covered services. In such arrangements, the group or organization has a financial incentive to control the cost of care.

Claims Payment for Nonparticipating Providers and Use of Claims Software
If your plan includes coverage for out-of-network services, and you obtain coverage under this portion of your plan, you should be aware that Aetna generally determines payment for an out-of-network provider by referring to (i) commercially available data reflecting the customary amount paid to most providers for a given service in that geographic area or (ii) by accessing other contractual arrangements. If such data is not commercially available, our determination may be based upon our own data or other sources. Aetna may also use computer software (including ClaimCheck®) and other tools to take into account factors such as the complexity, amount of time needed and manner of billing. You may be responsible for any charges Aetna determines are not covered under your plan.

Technology Review
Aetna reviews new medical technologies, behavioral health procedures, pharmaceuticals and devices to determine which one should be covered by our plans. And we even look at new uses for existing technologies to see if they have potential. To review these innovations, we may:
- Study medical research and scientific evidence on the safety and effectiveness of medical technologies.
- Consider position statements and clinical practice guidelines from medical and government groups, including the federal Agency for Health Care Research and Quality.
- Seek input from relevant specialists and experts in the technology
- Determine whether the technologies are experimental or investigational. You can find out more on new tests and treatments in our Clinical Policy Bulletins.

Prescription Drugs
If your plan covers outpatient prescription drugs, your plan may include a preferred drug list (also known as a "drug formulary"). The preferred drug list includes a list of prescription drugs that, depending on your prescription drug benefits plan, are covered on a preferred basis. Many drugs, including many of those listed on the preferred drug list, are subject to rebate arrangements between Aetna and the manufacturer of the drugs. Such rebates are not reflected in and do not reduce the amount you pay to your pharmacy for a prescription drug. In addition, in circumstances where your prescription plan utilizes copayments or coinsurance calculated on a percentage basis or a deductible, your costs may be higher for a preferred drug than they would be for a nonpreferred drug.

Closed formulary benefit plans may use a formulary exclusions list. Under these benefit plans, a drug on this list will be excluded from coverage unless a medical exception is obtained. In addition, some benefit plans may include Aetna's precertification or step-therapy programs. Under the step therapy program, members must first try certain prerequisite medication(s) before a step-therapy drug will be covered.

The prescribing physician can submit a request for a medical exception to Aetna Pharmacy Management's Precertification Unit in writing, by phone, or on-line. Information provided must include member identification, medical history, and laboratory data necessary to review the request.

The request for medical exception will be reviewed along with the Aetna Pharmacy Clinical Policy Bulletin applicable to the medication. If the medical exception meets the criteria established in the clinical policy bulletin, Aetna will notify the physician and member of the authorization. If an Aetna medical director determines the drug is not approved for coverage, an adverse determination letter will be sent to the member and provider. The notice will explain the reason for the denial of coverage and the appeal process.

For information regarding how medications are reviewed and selected for the preferred drug list, please refer to Aetna's website at **www.aetna.com** or the Aetna Preferred Drug (Formulary) Guide. Printed Preferred Drug Guide information will be provided, upon request or if applicable, annually for current members and upon enrollment for

new members. Additional information can be obtained by calling Member Services at the toll-free number listed on your ID card. The medications listed on the preferred drug list are subject to change in accordance with applicable state law.

Your prescription drug benefit is generally not limited to drugs listed on the preferred drug list. Medications that are not listed on the preferred drug list (nonpreferred or non-formulary drugs) may be covered subject to the limits and exclusions set forth in your plan documents.

Covered nonformulary prescription drugs may be subject to higher copayments or coinsurance under some benefit plans. Some prescription drug benefit plans may exclude from coverage certain nonformulary drugs that are not listed on the preferred drug list. If it is medically necessary for you to use such drugs, your physician (or pharmacist in the case of antibiotics and analgesics) may contact Aetna to request coverage as a medical exception. Check your plan documents for details.

In addition, certain drugs may require precertification or step-therapy before they will be covered under some prescription drug benefit plans. Step-therapy is a different form of precertification which requires a trial of one or more "prerequisite therapy" medications before a "step therapy" medication will be covered. If it is medically necessary for you to use a medication subject to these requirements, your physician can request coverage of such drug as a medical exception.

You may determine which medications are included in the Step Therapy Program and require trial of prerequisite drugs through any of the following methods:

- Contacting Member services via the phone number on your ID card
- Via the public web site www.aetna.com/formulary
- Via the “Medication Search” application on the web site above
- Accessing member specific coverage information via Aetna’s secure member web site -- Aetna Navigator

In addition, some benefit plans include a mandatory generic drug cost-sharing requirement. In these plans, you may be required to pay the difference in cost between a covered brand name drug and its generic equivalent in addition to your copayment if you obtain the brand-name drug. Nonprescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received and/or available upon enrollment) are not covered, and medical exceptions are not available for them.

Depending on the plan selected, new prescription drugs not yet reviewed for possible addition to the preferred drug list are either available at the highest copay under plans with an "open" formulary, or excluded from coverage unless a medical exception is obtained under plans that use a "closed" formulary. These new drugs may also be subject to precertification or step-therapy.

You should consult with your treating physician(s) regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding terms, conditions and limitations of coverage. If you use the mail order prescription program of Aetna Rx Home Delivery, LLC, or the Aetna Specialty Pharmacy[SM] specialty drug program, you will be acquiring these prescriptions through an affiliate of Aetna. Aetna’s negotiated charge with Aetna Rx Home Delivery® and Aetna Specialty Pharmacy may be higher than their cost of purchasing drugs and providing pharmacy services. For these purposes, Aetna Rx Home Delivery's and Aetna Specialty Pharmacy’s cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

Updates to the Drug Formulary
You can obtain formulary information from the Internet at **www.aetna.com/formulary**, or by calling your Member Services toll-free number.

Behavioral Health Network
Behavioral health care services are managed by Aetna, who is responsible for making initial coverage determinations and coordinating referrals to Aetna’s provider network. As with other coverage determinations, you may appeal adverse behavioral health care coverage determinations in accordance with the terms of your health plan.

The type of behavioral health benefits available to you depends upon the terms of your health plan. If your health plan includes behavioral health services, you may be covered for mental health conditions and/or drug and alcohol abuse services, including inpatient and outpatient services, partial hospitalizations and other behavioral health services. You can determine the type of behavioral health coverage available under the terms of your plan and how to access services by calling the Aetna Member Services number listed on your ID card.

If your health plan includes behavioral health services, you may be covered for mental health conditions and/or drug and alcohol abuse services. You can determine the type of behavioral health coverage available under the terms of your plan by calling the Aetna Member Services number listed on your ID card. If you have an emergency, call 911 or your local emergency hotline, if available. For routine services, access covered behavioral health services available under your health plan by the following methods:

Call the toll-free Behavioral Health number (where applicable) listed on your ID card or if no number is listed, call the Member Services number listed on your ID card for the appropriate information.

Where required by your plan, call your PCP for a referral to the designated behavioral health provider group. When applicable, an employee assistance or student assistance professional may refer you to your designated behavioral health provider group.

You can access most outpatient therapy services without a referral or pre-authorization. However, you should **first** consult with Member Services to confirm that any such outpatient therapy services do not require a referral or pre-authorization.

Behavioral Health Provider Safety Data Available
For information regarding our Behavioral Health provider network safety data, please go to **www.aetna.com** and review the quality and patient safety links posted: **http://www.aetna.com/docfind/quality.html#jcaho**. You may select the quality checks link for details regarding our providers' safety reports.

Behavioral Health Prevention Programs
Aetna Behavioral Health offers two prevention programs for our members: Perinatal Depression Education, Screening and Treatment Referral Program also known as "Mom's to Babies Depression Program" and Identification and Referral of Adolescent Members Diagnosed With Depression Who Also Have Co-morbid Substance Abuse Needs. For more information on either of these prevention programs and how to use the programs, ask Member Services for the phone number of your local Care Management Center.

Clinical Policy Bulletins
Aetna's CPBs describe Aetna's policy determinations of whether certain services or supplies are medically necessary or experimental or investigational, based upon a review of currently available clinical information. Clinical determinations in connection with individual coverage decisions are made on a case-by case basis consistent with applicable policies.

Aetna's CPBs do not constitute medical advice. Treating providers are solely responsible for medical advice and for your treatment. You should discuss any CPB related to your coverage or condition with your treating provider.

While Aetna's CPBs are developed to assist in administering plan benefits, they do not constitute a description of plan benefits. Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. You and your providers will need to consult the benefit plan to determine if there are any exclusions or other benefit limitations applicable to this service or supply.

CPBs are regularly updated and are therefore subject to change. Aetna's CPBs are available online at **www.aetna.com**.

Precertification
Precertification is the process of collecting information prior to inpatient admissions and performance of selected ambulatory procedures and services. The process permits advance eligibility verification, determination of coverage,

and communication with the physician and/or you. It also allows Aetna to coordinate your transition from the inpatient setting to the next level of care (discharge planning), or to register you for specialized programs like disease management, case management, or maternity management programs. In some instances, precertification is used to inform physicians, members and other health care providers about cost-effective programs and alternative therapies and treatments.

Certain healthcare services, such as hospitalization or outpatient surgery, require precertification with Aetna. When you are to obtain services requiring precertification from a participating provider, the provider is responsible to precertify those services prior to treatment. If you self-refer for covered benefits, it is your responsibility to contact Aetna to precertify those services which require precertification to avoid a reduction in benefits paid for that service.

Utilization Review
"Utilization review" means the review to determine whether health care services that have been provided, are being provided or are proposed to be provided are **Medically Necessary** or are **Experimental or Investigational Procedures**. An "adverse determination" means a utilization review determination that an admission, extension of stay, or other health care services, is not medically necessary.

To contact the Utilization Review Agent, call Member Services at the toll-free number on your ID card or call 1-888-982-3862. Doctors or health care professionals who have questions about your coverage can write or call our Patient Management department. The address and phone number are on your ID card. The Utilization Review Agent is available during regular business hours (8:00 am - 4:00 pm ET) Monday though Friday. For calls made after business hours or during the weekend, the Member can leave a message.

Whether a utilization review determination is made before, during or after services are provided, any adverse determination, including a claim denial, will be made by a clinical peer reviewer and all notices of adverse determinations will include the specific reasons for the denial as well as information about your rights to appeal, including your right to appeal a final adverse determination to the New York State External Review Program. All final adverse determinations will be made by a clinical peer reviewer other than the clinical peer reviewer who made the initial adverse determination.

Prospective Review
Prospective review, (pre-service review) is the review for approval of a claim before the service has taken place. Determination will be communicated within three business days of receipt of the claim. Aetna will notify **Member,** or **Member's** designee, and **Member's** health care provider of the determination by telephone and in writing. If additional information is needed, the Member or their provider has 45 calendar days to submit the information. Aetna will make a decision within 3 business days of receipt of the needed information. If Aetna does not receive the needed information, Aetna shall render a decision within 15 days from the end of the 45th day.

With respect to Pre-Service Urgent Care Claims, Aetna will make a notification by telephone and in writing within 24 hours after receipt of the claim. If more information is needed, Aetna will request it within 24 hours. The Member, the Member's designee and the Member's provider will have 48 hours to submit the needed information. Aetna will make a determination and provide notice to the Member, the Member's designee and the Member's Provider by telephone and in writing within 48 hours after Aetna's request of the information.

Concurrent Review
The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members receiving inpatient services. All inpatient services extending beyond the initial certification period will require concurrent review. Determination will be communicated within one business day by telephone and in writing to the member or a designee, which may be your health care provider. If Aetna needs information to make a decision, the concurrent review decision will be made as soon as possible but no later than one business day from receipt of all needed information or within 15 calendar days of the request, whichever is earlier.

With respect to Concurrent Claims that involve urgent matters, Aetna will make a determination and will notify the Member, the Member's designee and the Member's provider by telephone and in writing within 24 hours after receipt of the request, if the request for additional information is made at least 24 hours prior to the end of the period for which benefits have been approved. Requests that are not made within this time will be determined within the

timeframes for Pre Service Urgent Care Claims. It Aetna has approved a course of treatment, Aetna will not reduce or terminate the approved services before giving the Member enough prior notice of the reduction or termination so that the Member can complete the appeal process before the services are reduced or terminated.

Discharge Planning
Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits for the member after s/he is released from the inpatient facility.

Retrospective Record Review
The purpose of retrospective review is to review initial requests for certification received after discharge or after the provision of services, retrospectively analyze potential quality and utilization issues, initiate appropriate follow-up action based on quality or utilization issues, and review all appeals of inpatient concurrent review decisions for coverage of health care services. Our effort to manage the services provided to you includes the retrospective review of claims submitted for payment, and of medical records submitted for potential quality and utilization concerns. Aetna will make a decision in writing as soon as possible but not later than 30 calendar days after receipt of the claim. If the member does no provide all needed information, Aetna will allow the member 45 days to send in the needed information. Aetna will make a decision within 15 days of receipt of needed information. If the information is not received after 45 days, Aetna will make a decision based upon the available information and will notify the member of the decision within 15 days.

Reconsideration Review
In the event that an adverse determination is made without attempting to discuss the matter with your health care provider who recommended the health care service, procedure or treatment under review, the provider has an opportunity to request reconsideration through discussion with the clinical peer reviewer. Reconsideration shall occur in one business day of the receipt of the request. Reconsideration does not apply to retrospective reviews.

We may reverse a preauthorized treatment service or procedure retrospectively: (1) when the relevant medical information presented to us is materially different from the information presented during the original preauthorization; (2) when the relevant medical information presented to us upon the retrospective review existed at the time of preauthorization but was withheld from or not made available to us; and (3) we were not aware of the existence of the information at the time of the preauthorization review; and (4) if we had been aware of this information, the treatment service or procedure being requested would not have been authorized. The determination is to be made using the same specific standards, criteria or procedures as used during the preauthorization review.

You have the right to designate a representative to act on your behalf, or to have any person who has legal responsibility to make medical care decisions for you.

All clinical denials will be made by a clinical peer reviewer and all denial notices will contain information about the basis for the decision.

Appeals Procedure

Definitions

Adverse determination: A denial; reduction; termination of; or failure to provide (in whole or in part) a service because it is determined to be an **Experimental or Investigational Procedure** or not **Medically Necessary** or appropriate.

Such **adverse determination** may be based on, among other things:

- A **Member's** eligibility for coverage;
- Plan limitations or exclusions;
- The results of any Utilization Review activities (determination as to whether or not an admission, extension of stay, or other health care service or supply is **Medically Necessary**, based on the information provided).

Denials of out of network claims on the basis that a service is not materially different than an alternate service available under the **HMO Certificate** shall not constitute an **adverse determination**.

Appeal: An oral or written request to **Aetna** to reconsider an **adverse determination**.

Complaint: Any oral or written expression of dissatisfaction about quality of care or the operation of the **HMO** plan.

Concurrent Care Claim Extension: A request to extend a previously approved course of treatment or provide additional services or home health care services following discharge from an inpatient hospital admission.

Expedited Appeal: Appeal of an **adverse determination** involving (1) continued or extended services, procedures and treatments or additional services for a **Member** undergoing a course of continued treatment prescribed by a **Health Care Provider**, or home health care or rehabilitation facility services following discharge from an inpatient hospital admission or (2) an **adverse determination** in which the health care provider believes an immediate appeal is warranted where there is imminent or serious threat to the health of the **Member**, except any retrospective determination, or (3) for an adverse determination involving an urgent care claim. **Aetna** will provide reasonable access by the **Health Care Provider** to the clinical peer reviewer within one business day of receipt of receipt of the appeal.

Grievance: A request for review of a determination, other than a determination meeting the definition of **adverse determination**.

Health Care Provider: A health care professional or a facility licensed pursuant to NY law.

Pre-service Claim: Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

Post-Service Claim: Any claim that is not a "Concurrent Care Claim Extension," an "Urgent Care Claim" or a "Pre-Service Claim."

Urgent Care Claim: Any claim for medical care or treatment with respect to which a delay: (a) could seriously jeopardize the life or health of the **Member** or the ability of the **Member** to regain maximum function; or (b) in the opinion of a **Physician** with knowledge of the **Member's** medical condition would subject the **Member** to severe pain that cannot be adequately managed without the requested treatment.

Out-of Network Denial: A denial of a request for preauthorization to receive a health service from an out of network provider on the basis that such service is not materially different from a service available under the **HMO Certificate**. The Notice of denial of such service shall include information explaining what information must be submitted to appeal the denial.

Rare Disease: A life threatening or disabling condition or disease that: (1)(a) is currently or has been subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network; or (b) affects fewer than 200,000 United States residents per year; and (2) for which there does not exist a standard health service or procedure covered by **HMO** that is more clinically beneficial than the requested health service or treatment.

Claim Determinations

Pre-Service Claims
HMO will make notification of a claim determination as soon as possible but not later than 3 business days after receipt of the claim. In the event **Member** fails to provide all of the necessary information for **HMO** to make a claim determination, **HMO** will request such information within 3 days of receipt of the claim and will allow the **Member** 45 days to submit the necessary information. **HMO** will make a claim determination within 3 business days after receipt of such information. If the information requested is not received by **HMO** after 45 days, **HMO** will make a determination based on information available and will notify **Member** of the decision within 15 days. **HMO** will notify **Member,** or **Member's** designee, and **Member's** health care provider of the determination by

telephone and in writing. Notification will include the total of approved services, the date of the onset of services and the next review date.

With respect to Pre-Service Urgent Care Claims, **HMO** will make a notification by telephone and in writing within 24 hours after receipt of the claim. If more information is needed, Aetna will request it within 24 hours. The **Member**, the **Member's** designee and the **Member's Health Care Provider** will have 48 hours to submit the needed information. **HMO** will make a determination and provide notice to you or your designee and your **Health Care Provider** by telephone and in writing within 48 hours of the earlier of **HMO's** receipt of the information or the end of the 48 hour period after **HMO's** request of the information.

Concurrent Care Claim Extension
Following a request for a **concurrent care claim extension**, **HMO** will make notification of a claim determination by telephone and in writing to **Member**, **Member's** designee and **Member's** health care provider as soon as possible, but no later than one day after receipt of the necessary information, or 15 days from receipt of the claim. With respect to home health care services following an inpatient hospital admission, **HMO** will make the notification no later than 72 hours after receipt of the necessary information when the day subsequent to the request falls on a weekend or a holiday. But, coverage shall not be denied on the basis of medical necessity or lack of authorization while the decision is pending.

With respect to home health care services following an inpatient hospital admission, **HMO** will make the notification no later than 72 hours after receipt of the necessary information when the day subsequent to the request falls on a weekend or a holiday. But, coverage shall not be denied on the basis of medical necessity or lack of authorization while the decision is pending.

With respect to Concurrent Claims that involve urgent matters, **AETNA** will make a determination and will notify the **Member**, the **Member's** designee and the **Member's Health Care Provider** by telephone and in writing within 24 hours after receipt of the request, if the request for additional information is made at least 24 hours prior to the end of the period for which benefits have been approved. Requests that are not made within this time will be determined within the timeframes for Pre Service Urgent Care Claims. It **AETNA** has approved a course of treatment, **AETNA** will not reduce or terminate the approved services before giving the **Member** enough prior notice of the reduction or termination so that the **Member** can complete the appeal process before the services are reduced or terminated.

Post-service Claims
AETNA will make notification of a claim determination in writing as soon as possible but not later than 30 calendar days after receipt of the claim. In the event **Member** fails to provide all of the necessary information for **AETNA** to make a claim determination, **AETNA** will allow **Member** 45 days to submit the necessary information, and will make a claim determination within 15 days after receipt of such information. If the information requested is not received by **AETNA** after 45 days, **AETNA** will make a determination based on information available and will notify **Member** of the decision within 15 days.

The Notice of **adverse determination** will include:

- The reasons for the **adverse determination**, including reference to specific plan provisions upon which the determination is based and the clinical rationale, if any;
- A description of the **Aetna's** review procedures, including a statement of claimants' rights to bring a civil action.
- Instructions on how to start the appeals, expedited appeals and external appeals process;
- Notice of the availability, upon request, of the clinical review criteria used to make the **adverse determination**. This notice will also specify what necessary additional information, if any, must be provided to, or obtained by, **AETNA** in order to render a decision on **appeal**.

In the event that **AETNA** renders an **adverse determination** without first attempting to discuss the matter with the **Member's Health Care Provider** who specifically recommended the service, the health care provider will have the opportunity to request a reconsideration of the **adverse determination**. Except for post-service claims, such

reconsideration will occur within one business day of receipt by **AETNA** of the request. If the **adverse determination** is upheld, **AETNA** will provide notice, as described above.

If **AETNA** does not render a decision within the period set forth above, **Member** may consider this to be an **adverse determination**, subject to **appeal**.

Complaints

If the **Member** is dissatisfied with the service he or she receives from **AETNA** or wants to complain about a **Health Care Provider**, **Member** must call or write Member Services. The **Member** must include a detailed description of the matter and include copies of any records or documents that **Member** thinks are relevant to the matter. **AETNA** will review the information and provide **Member** with a written response within 15 calendar days of the receipt of the **complaint**, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell **Member** what he or she needs to do to seek an additional review.

The Member Services telephone number is on the **Member's** ID card. If **Member** is required to leave a recorded message, the message will be acknowledged within one business day after the call was recorded.

Appeals of Out-of Network Benefit Denials

The **Member** may appeal a denial of out-of-network benefits based on the fact that an alternate service is available under **HMO Certificate** by submitting:

- a written statement from **Member's Physician** that the service is materially different from the health service approved to treat **Member's** medical needs under the **HMO Certificate**; and
- two documents from available medical and scientific evidence, stating that the out-of-network service is likely to be more clinically beneficial than the alternate service under the **HMO Certificate**, and the adverse risk would not be substantially increased.

Appeals of Adverse Determinations

Member may submit an **appeal** if **AETNA** gives notice of an **adverse determination**. **AETNA** provides for two levels of **appeal**. It will also provide an option to request an external review of the **adverse determination.**

The **Member** has 180 calendar days following the receipt of notice of an **adverse determination** to request the level one **appeal**. The **appeal** may be submitted orally or in writing. The request should include:

- **Member's** name;
- **Member's** employer's name;
- A statement from **Member's Health Care Provider**;
- A copy of **Aetna's** notice of an **adverse determination**;
- **Member's** reasons for making the **appeal**; and
- Any other information **Member** would like to have considered.

The **Member** should send the **appeal** to Member Services at the address shown on **Member's** ID Card, or call in the **appeal** to Member Services, using the toll-free telephone number shown on the ID Card.

The **Member** may also choose to have an authorized designee make the **appeal** on his or her behalf by providing written consent to **AETNA**. **Member's Health Care Provider** may make the appeal in connection with the **adverse determinatio**n for a **post service claim**.

Level One Appeal

A level one **appeal** of an **adverse determination** shall be decided by **AETNA** personnel not involved in making the **adverse determination**.

Expedited Appeals

AETNA has established an expedited **appeals** process for **adverse determinations** involving **urgent care** claims, **concurrent care claim extensions** and **pre-service claims**. **HMO** will render a decision involving **urgent care, concurrent claim extension** and **pre-service claims** within the earlier of 72 hours of receipt of the **appeal** or 2 business days from receipt of the necessary information to conduct the **appeal**.

Pre-Service Claims (other than those subject to an Expedited Appeal)
AETNA shall issue a decision within 15 days of receipt of the **appeal**.

Post-Service Claims
AETNA shall issue a decision within the earlier of 15 days of receipt of the necessary information to conduct the **appeal** or 30 days of receipt of the request for an **appeal**.

The notice of the appeal determination will include:

- If the **adverse determination** is upheld, the reason for the determination, including the clinical rationale for it; and
- A notice of **Member's** right to an external appeal, together with information and a description of the external **appeals** process. **Member** also has the option to request a Level 2 **appea**l from **AETNA**.

If **HMO** does not render an appeal determination for a Standard or Expedited **appeal** within the timeframes set forth above, the **adverse determination** will be reversed.

Level Two Appeal

If **AETNA** upholds an **adverse determination** at the first level of **appeal**, **Member** or **Member's** authorized representative has the option to file a level two **appeal**, or request an External Appeal. The Level Two **appeal**, if requested, must be submitted within 60 calendar days following the receipt of notice of a level one **appeal** determination**.** Please note that if the **Member** decides to pursue a Level Two **appeal** and wait for a decision from **AETNA,** the **Member** may miss the deadline to request an External Appeal from the New York State Insurance Department. Also, the **Member** may wish to end the Level Two **appeal** once the **Member** receives notice from the New York State Insurance Department that the request for an External Appeal has been received and is being sent out for review.

A Level Two **appeal** of an **adverse determination** of an **expedited appeal** shall be decided by **AETNA** personnel not involved in making the **adverse determination**. A Level Two **appeal** of an **adverse determination** of a **pre-service claim** or a **post-service claim** will be reviewed by the **Aetna's** Appeals Committee.

Expedited Appeals (Urgent Care Claims, Concurrent Care Claims Extensions and Pre-Service Claims)
AETNA shall issue a decision within 24 hours of receipt of the request for a level two **appeal** for these claims.

Pre-Service Claims (other than those subject to an **Expedited Appeal**)
AETNA shall issue a decision within 15 calendar days of receipt of the request for level two **appeals**.

Post-Service Claims
AETNA shall issue a decision within 30 calendar days of receipt of the request for a level two **appeal**.

*At any time during the complaints process, the **Member** has the right to contact the New York State Department of Health at 1-800-206-8125, or by mail at New York State Department of Health, Division of Managed Care, Bureau of Managed Care Certification and Surveillance, Empire State Plaza, Corning Tower, Room 1911, Albany, New York 12237-0062.*

Grievances

The **Member** may submit a **grievance**, orally or in writing, to **AETNA** with respect to review of any determination other than an **adverse determination**.

The **AETNA** will acknowledge receipt of the **grievance** within 15 calendar days after its receipt by the **AETNA**.

Grievance Determinations

Expedited Grievances
HMO will resolve an expedited **grievance** within the lesser of 48 hours from receipt of the necessary information or 72 hours from receipt of the grievance when delay would significantly increase the risk to a **Member's** health.

Standard Grievances
For other **grievances**, **HMO** will resolve the grievance within the lesser of 30 days from receipt of the necessary information or 15 days from receipt of the grievance for pre-service claims grievances, or 30 days after receipt of a post service claims grievance.

Grievance Appeals
Following receipt of **AETNA'S** grievance decision, if you disagree, you have 60 business days to submit a written appeal to Aetna. Aetna will acknowledge receipt of the appeal within 15 business days of its receipt of the appeal.

Expedited Grievances
AETNA will render a decision within 2 business days after receipt of the appeal where a delay would significantly increase the risk to the Member's health.

Standard Grievances
For other **grievances**, **AETNA** will render a decision within 30 days from receipt of all necessary information to resolve the grievance.

External Review

Right to an External Appeal

Under certain circumstances, the **Member** has a right to an external appeal of a denial of coverage. Specifically, if **AETNA** has denied coverage on the basis that the a) service is not **Medically Necessary** or is an **Experimental or Investigational Procedure** or (b) such service is provided out-of-network and an alternate is available under the **HMO Certificate**, the **Member** may **Appeal** that decision to an External Appeal Agent, an independent entity certified by the State to conduct such appeals.

Right to Appeal a Determination that a Service is not Medically Necessary

If the **AETNA** has denied coverage on the basis that the service is not **Medically Necessary,** the **Member** may **appeal** to an External Appeal Agent if **Member** satisfies the following criteria listed below:

- The service must otherwise be a **Covered Service** under this **Certificate**; and
- The **Member** must have received a final **adverse determination** through the first level of **Aetna's** internal review process and the **AETNA** must have upheld the denial or the Member and the **AETNA** must agree in writing to waive any internal appeal.

Right to Appeal a Determination that a Service is Experimental or Investigational
If a **Member** has been denied coverage on the basis that the service is an **Experimental or Investigational Procedure**, the **Member** must satisfy the following criteria:

- The service must otherwise be a **Covered Service** under this **Certificate**; and
- The **Member** must have received a final **adverse determination** through the first level of the **Aetna's** internal **appeal** process and **AETNA** must have upheld the denial or the **Member** and **AETNA** must agree in writing to waive any internal **appeal**.

In addition, the **Member's** attending **Physician** must certify that the **Member** has a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one which, according to the current diagnosis of the attending **Physician**, has a high probability of death. A "disabling condition or disease" is any medically determinable physical or medical impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months, which renders the **Member** unable to engage in

any substantial gainful activities. In the case of a dependent child under the age of 18, a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

The **Member's** attending **Physician** must also certify that the life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered under this **Certificate** or one for which there exists a clinical trial (as defined by law) or **rare disease** treatment. In the case of a **rare disease**, the attending **Physician** may not be the treating **Physician**.

The **Member's** attending **Physician** must be a licensed, board certified or board eligible physician qualified to practice in the area of practice appropriate to treat the **Member's** life threatening or disabling condition.

In addition, the **Member's** attending **Physician** must have recommended at least one of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to the **Member** than any standard **Covered Service** (only certain documents will be considered in support of this recommendation – the **Member's** attending **Physician** should contact the State in order to obtain current information as to what documents will be considered acceptable); or in the case of a **rare disease**, based on the **Physician's** certification and such other evidence as the **Member**, the **Member's** designee or the **Member's** attending **Physician** may present; or
- A clinical trial for which the **Member** is eligible (only certain clinical trials can be considered).

Right to **Appeal** a Determination that an Alternate Service is available under **HMO Certificate**.

If coverage for an out-of-network service (other than a clinical trial, which is covered immediately above), has been denied on appeal on the basis that an alternate service is available under the **HMO Certificate, Member** may **appeal** to an External Appeal Agent if **Member** satisfies the following criteria listed below:

- The service, procedure or treatment must otherwise be a **Covered Service** under **HMO**; and
- **Member** must have received a final **adverse determination** through the first level of **HMO's** internal review process and **HMO** must have upheld the denial, or **Member** and **HMO** must agree in writing to waive any internal appeal.
- The attending **Physician** certifies that such out-of-network service is (i) materially different than the alternate service under the **HMO Certificate**; and (ii) based on two documents from available medical and scientific evidence, such service is likely to be more clinically beneficial than the alternate service under the **HMO Certificate** and the adverse risk would not be substantially increased.

For the purposes of this section, the **Member's** attending **Physician** must be a licensed, board certified or board eligible **Physician** qualified to practice in the area appropriate to treat the **Member's** life-threatening or disabling condition or disease, or **Rare Disease**. In the case of a **rare disease**, the attending **Physician** may not be the treating **Physician**.

The External Appeal Process

If, through the first level of **AETNA's** internal **appeal** process, the **Member** has received a final **adverse determination** upholding a denial of coverage on the basis that the service is not **Medically Necessary** or is an **Experimental or Investigational Procedure**, or an alternate service is available out-of-network, **Member** has 45 days from receipt of such notice to file a written request for an external appeal. If Member does not file for an external appeal within 45 days, the Member will lose the right to the external appeal. If **Member** and **AETNA** have agreed to waive any internal **appeal**, the **Member** has 45 days from the receipt of such waiver to file a written request for an external **appeal**. **AETNA** will provide an external appeal application with the final **adverse determination** issued through the first level of **AETNA's** internal **appeal** process or its written waiver of an internal **appea**l.

The **Member** may also request an external **appeal** application from the New York State Department of Insurance by calling 1-800-400-8882 or at their website: www.ins.state.ny.us.

The **Member** shall submit the completed application to the New York State Department of Insurance at the address listed in the application. If **Member** satisfies the criteria for an external **appeal**, the State will forward the request to a certified External Appeal Agent. The **Member** will have the opportunity to submit additional documentation with the request. If the External Appeal Agent determines that the information **Member** submits represents a material change from the information on which **AETNA** based its denial, the External Appeal Agent will share this information with **AETNA** in order for it to exercise its right to reconsider its decision. If **AETNA** chooses to exercise this right, **AETNA** will have three (3) business days to amend or confirm its decision. Please note that in the case of an expedited **appeal** (described below), **AETNA** does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within thirty (30) days of receipt of the completed application. The External Appeal Agent may request additional information from the **Member**, the **Member's Physician or Health Care Provider** or the **AETNA**. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify the **Member** or the **Member's Physician**, where appropriate in writing of its decision within two (2) business days.

If the **Member's** attending **Physician or Health Care Provider** certifies that a delay in providing the service that has been denied poses an imminent or serious threat to the **Member's** health, the **Member** may request an expedited external **appeal**. In that case, the External Appeal Agent must make a decision within three (3) days of receipt of the completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify the **Member** and **AETNA** by telephone or facsimile of that decision. The **External Appeal Agent** must also notify the **Member** in writing of its decision.

If the External Appeal Agent overturns **Aetna's** decision that a service is not **Medically Necessary** or approves coverage of an **Experimental or Investigational Procedure** or determines that the out of network service, the **AETNA** will provide coverage subject to the other terms and conditions of this **Certificate**. If the External Appeal Agent approves coverage of an **Experimental or Investigational Procedure** that is part of a clinical trial, **AETNA** will only cover the costs of services required to provide treatment to Member according to the design of the trial. **AETNA** shall not be responsible for the costs of investigational drugs or devices; the costs of non-health care services; the costs of managing research; or costs which would not be covered under this **Certificate** for non-experimental or non-investigational procedures provided in such clinical trial.

The External Appeal Agent's decision is binding on both the **Member** and **AETNA**. The External Appeal Agent's decision is admissible in any court proceeding.

A **Physician or Health Care Provider** requesting an external **appeal** of an **adverse claim determination** involving a concurrent care claim, including when such **Physician or Health Care Provider** requests the external **appeal** as the **Member's** designee, shall not pursue reimbursement from any **Member** for services determined not **Medically Necessary** by the **External Appeals Agent**, except to collect a copayment, coinsurance or deductible.

Member's Responsibilities

Except as provided below under "Appeals of Admissions for or Provision or Continuation of Access to End of Life Care for Members Diagnosed with Advanced Cancer", it is the **Member's** responsibility to initiate the external **appeals** process. **Member** may initiate the external **appeal** process by filing a completed External Appeal application with the New York State Department of Insurance. The Member may designate an authorized representative at any time to pursue an external appeal. The **Member**, or **Member's** designee, may file an external **appeal** application; but if it's filed by **Member's** designee, **Member** must consent to it in writing. The Department of Insurance may request from **Member** written confirmation of the appointment of a designee. In addition, **Member's** attending **Physician or Health Care Provider** has the right to pursue an external **appeal** of a concurrent or a retrospective **adverse claim determination**. To do so, the attending **Physician or Health Care Provider** must complete an External Appeal application for health care providers. **Member** must sign an acknowledgment of the request and consent to release of any medical records.

Under New York State law, the completed request for **appeal** must be filed within 45 days of either: the date upon which **Member** receives written notification from **AETNA** that it has upheld a denial of coverage; or the date upon

which Member receives a written waiver of any internal **appea**l. **AETNA** has no authority to grant an extension of this deadline.

Covered Services and Exclusions

In general, this **Certificate** does not cover **Experimental or Investigational Procedures**. However, this **Certificate** shall cover an **Experimental or Investigational Procedure** approved by an External Appeal Agent in accordance with this section. If the External Appeal Agent approves coverage of an **Experimental or Investigational Procedure** that is part of a clinical trial, **AETNA** will only cover the costs of services required to provide treatment to you according to the design of the trial. **AETNA** shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this **Certificate** for non-experimental or non-investigational procedures provided in such clinical trial.

APPEALS OF ADMISSIONS FOR OR PROVISIONS OR CONTINUATION OF ACCESS TO END OF LIFE CARE FOR MEMBERS DIAGNOSED WITH ADVANCED CANCER

The following applies if a **Member**: (i) has been diagnosed with advanced cancer (with no hope of reversal of primary disease and fewer than 60 days to live, as certified by the **Member's Physician**); and (ii) the **Physician**, in consultation with the medical director of a facility specializing in the treatment of terminally ill patients and licensed pursuant to article 28 of the public health law, has determined that the **Member's** care would be appropriately provided by such facility.

In the event **AETNA** disagrees with the admission of or provision or continuation of care of the **Member** by the facility, **AETNA** must initiate an expedited external appeal as described above. However, until a decision is rendered, such admission for, provision of or continuation of the care by the facility will not be denied, and **AETNA** will continue to provide such coverage. The decision of the external appeals agent will be binding on all parties.

AETNA will keep records of **Member's** complaint for 7 years.

Member Rights and Responsibilities

Information

- Know the names and qualifications of the health care professionals involved in your medical treatment.
- Obtain complete and current information concerning a diagnosis, treatment and prognosis from a physician or other provider in terms you can be reasonably expected to understand. When it is not advisable for such information to be given to the Member, it shall be made available to an appropriate person on the Member's behalf.
- Get up-to-date information about the services covered or not covered by your plan and any applicable limitations or exclusions.
- Know how your plan decides what services are covered.
- Get information about copayments and fees that you must pay.
- Get up-to-date information about the health care professionals, hospitals and other providers that participate in the plan.
- Be advised how to file a complaint, grievance or appeal with the plan.
- Know how the plan pays network health care professionals for providing services to you.
- Receive information from health care professionals about your medications, including what the medications are, how to take them and possible side effects.
- Receive from health care professionals as much information about any proposed treatment or procedure as you may need in order to give informed consent or refuse a course of treatment. Except in an emergency, this information should include a description of the proposed procedure or treatment, the potential risks and benefits involved, any alternate course of treatment (even if not covered) or nontreatment and the risks involved in each, and the name of the health care professionals who will carry out the procedure or treatment. When it is not advisable to give such information to you, your doctor may give such information to a person acting on your behalf.
- Be informed by participating providers about continuing health care requirements following discharge from inpatient or outpatient facilities.

- Be advised if a health care professional proposes to use an experimental treatment or procedure in your care. You have the right to refuse to participate in research projects.
- Receive an explanation regarding noncovered services.
- Receive a prompt reply when you ask questions about the plan or request information.
- Receive a copy of the plan's Member Rights and Responsibilities statement.

Access to Care

- Obtain primary and preventive care from the PCP you chose from the plan's network.
- Change your PCP to another available PCP who participates in the plan.
- Obtain necessary care from participating network specialists, hospitals and other providers.
- Be referred to participating network specialists who are experienced in treating your chronic illness.
- Be advised by your health care professionals how to schedule appointments and get health care during and after office hours, including continuity of care.
- Be advised how to get in touch with your PCP or a backup physician 24 hours a day, every day.
- Call 911 (or the local emergency hotline) or go to the nearest emergency facility when you have an emergency medical condition as defined in your plan documents.
- Receive urgently needed medically necessary care.

Freedom to Make Decisions

- Exercise these rights regardless of your race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion, national origin, cultural or educational background, economic or health status, English proficiency, reading skills or source of payment for your care.
- Have any person who has legal responsibility to make medical care decisions for you exercise these rights on your behalf.
- Refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.
- Complete an advance directive, living will or other directive and give it to your health care professionals.
- Know that you or your health care professionals cannot be penalized for filing a complaint or appeal.

Personal Rights

- Be treated with respect for your privacy and dignity.
- Have your medical records kept private, except when permitted by law or with your approval.
- Help your health care professionals make decisions about your health care.

Input

- Have your health care professionals help you to make decisions about the need for services and with the complaint process.
- Suggest changes in the plan's policies and services. To submit suggestions on the plan's policies, please write to us at the below address:

  Aetna Health Inc.
  980 Jolly Road
  U12N, Blue Bell, PA 19422

Exercise Your Rights

- Choose a PCP from the plan's network and form an ongoing patient-physician relationship.
- Help your health care professionals make decisions about your health care.

Follow Instructions

- Read and understand your plan and benefits. Know the copayments and what services are covered and what services are not covered.
- Follow the directions and advice on which you and your health care professionals have agreed.
- See the specialists your PCP refers you to.
- Make sure you have the appropriate authorization for certain services, including referrals and precertification for inpatient hospitalization and out-of-network treatment.
- Show your membership card to health care professionals before getting care from them.

- Pay the copayments required by your plan.
- Promptly follow your plan's complaint processes if you believe you need to submit a complaint.
- Treat all providers, their staff members and the staff of the plan with respect.
- Not be involved in dishonest activity directed at the plan or at any provider.

Communicate
- Tell your health care professionals if you do not understand the treatment you receive and ask if you do not understand how to care for your illness.
- Tell your health care professionals promptly when you have unexpected problems or symptoms.
- Consult with your PCP for referrals to nonemergency covered specialist or hospital care.
- Understand that network physicians and other health care professionals who care for you are not employees of Aetna and that Aetna does not control them.
- Contact Member Services if you do not understand how to use your benefits.
- Give correct and complete information to physicians and other health care professionals who care for you.
- Advise Aetna about other medical insurance coverage you or plan members in your family may have.
- Ask your treating physician about all treatment options.
- Ask about the physician's compensation arrangement with Aetna.
- You may have additional rights and responsibilities depending on state laws applicable to your plan.

Advance Directives
An advance directive is a legal document that states your wishes for medical care. It can help doctors and family members determine your medical treatment if, for some reason, you can't make decisions about it yourself.

There are three types of advance directives:
- Living will — spells out the type and extent of care you want to receive.
- Durable power of attorney — appoints someone you trust to make medical decisions for you.
- Do-not-resuscitate order — states that you don't want to be given CPR if your heart stops or if you stop breathing.

You can create an advance directive in several ways:
- Get an advance medical directive form from a health care professional. Certain laws require health care facilities that receive Medicare and Medicaid funds to ask all patients at the time they are admitted if they have an advance directive. You don't need an advance directive to receive care. But we are required by law to give you the chance to create one.
- Ask for an advance directive form at state or local offices on aging, bar associations, legal service programs, or your local health department.
- Work with a lawyer to write an advance directive.
- Create an advance directive using computer software designed for this purpose.

(Advanced Directives and Do Not Resuscitate Orders. American Academy of Family Physicians, March 2005. Available at ***http://familydoctor.org/003.xml?printxml****)*

Privacy Notice
Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to your physical or mental health or condition, the provision of health care to you, or payment for the provision of health care to you. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify you.

When necessary or appropriate for your care or treatment, the operation of our health plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. Participating network providers

are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claims payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health claims analysis and reporting; health services research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health plans. To the extent permitted by law, we use and disclose personal information as provided above without your consent. However, we recognize that you may not want to receive unsolicited marketing materials unrelated to your health benefits. We do not disclose personal information for these marketing purposes unless you consent. We also have policies addressing circumstances in which you are unable to give consent.

To obtain a hard copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, **please write to Aetna's Legal Support Services Department at 151 Farmington Avenue, W121, Hartford, CT 06156** You can also visit our Internet site at **www.aetna.com**. You can link directly to the Notice of Privacy Practices by selecting the "Privacy Notices" link at the bottom of the page.

Health Insurance Portability and Accountability Act
The following information is provided to inform you of certain provisions contained in the Group Health Plan, and related procedures that may be utilized by you in accordance with Federal law.

Additional Information Available Upon Request

In accordance with New York law, the following information is available to a Member or prospective member upon request by contacting the Member Services Department:

1. List of the names, business addresses, and official positions of the membership of the board of directors, officers, controlling persons, owners or partners of the plan.
2. The most recent certified financial statements of the plan, including a balance sheet and summary of receipts and disbursements prepared by a certified public accountant.
3. Copy of the most recent individual, direct-pay subscriber contracts.
4. Information relating to consumer complaints compiled pursuant to Section 210 of the New York insurance law.
4. Procedures for protecting the confidentiality of medical records and other enrollee information.
5. Drug formularies, if any, used by the plan and the inclusion/exclusion of individual drugs.
6. Written description of the organizational arrangements and ongoing procedures of the plan's quality assurance program.
7. Description of the procedures followed in making decisions about experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials.
8. Individual health practitioner affiliations with participating hospitals, if any.
9. Upon written request, specific written clinical review criteria relating to a particular condition or disease and, where appropriate, other clinical information which the plan might consider in its patient management program and the plan may include with the information a description of how it will be used in the patient management process, provided, however, that to the extent such information is proprietary to the plan, the enrollee or prospective enrollee shall only use the information for the purposes of assisting the enrollee or prospective enrollee in evaluating the covered services provided by the plan.
10. Written application procedures and minimum qualification requirements for health care providers considered by the plan.
11. Such other information as required by the Commissioner of Health provided that such requirements are promulgated pursuant to the state administrative procedure act.

Member Participation

An Aetna plan member is on the Board of Directors. This member representative is an active participant in overseeing the management and operation of Aetna. Moreover, we regularly send surveys to members requesting their views on the services received from participating providers and also seeking ideas and comments about their benefits, including Aetna's policies and procedures. We use this input to evaluate our services, policies and procedures.

Health Insurance Portability and Accountability Act

The following information is provided to inform you of certain provisions contained in the Group Health Plan, and related procedures that may be utilized by you in accordance with Federal law.

Special Enrollment Rights
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. To request special enrollment or obtain more information, contact your benefits administrator.

Request for Certificate of Creditable Coverage
If you are a member of an insured plan sponsor or a member of a self insured plan sponsor who has contracted with us to provide Certificates of Prior Health Coverage, you have the option to request a certificate. This applies to you if you are a terminated member, or are a member who is currently active but who would like a certificate to verify your status. As a terminated member, you can request a certificate for up to 24 months following the date of your termination. As an active member you can request a certificate at any time. To request a Certificate of Prior Health Coverage, please contact Member Services at the telephone number listed on your ID card.

AETNA HEALTH INC.
(NEW YORK)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

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

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

AETNA HEALTH INC.
(NEW YORK)

PATIENT PROTECTION AND AFFORDABLE CARE ACT AMENDMENT

This Amendment changes provisions in, or adds provisions to, your **HMO Certificate**, including any affected riders, endorsements or other amendments thereto, (hereinafter collectively called the "Group Plan") issued by **HMO** as required by the federal Patient Protection and Affordable Care Act. Except as otherwise provided in this Amendment, the provisions herein apply to all persons covered under the **HMO Certificate** ("**Members**").

This Amendment shall take effect on the Plan's plan year on or after September 23, 2010.

1. **Emergency Services.**

   A. **Emergency Condition Defined.** The definition of Emergency Medical Condition in the **HMO Certificate** is hereby deleted in its entirety and replaced with the following:

   Emergency Condition. A medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

   (1) Placing the health of the person afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;
   (2) Serious impairment to such person's bodily functions;
   (3) Serious dysfunction of any bodily organ or part of such person; or
   (4) Serious disfigurement of such person.

   B. **Emergency Services Defined.** The following definition is hereby added to your **HMO Certificate**:

   Emergency Services. A medical screening examination that is within the capability of the emergency department of a **Hospital**, including ancillary services routinely available to the emergency department to evaluate an **Emergency Condition**; and within the capabilities of the staff and facilities available at the **Hospital**, such further medical examination and treatment as are required to stabilize the patient.

   C. **Coverage. Emergency Services** are not subject to prior authorization requirements.

   D. **Cost-Sharing.** Any Copayment requirement in your **HMO Certificate** that applies to **Emergency Services** provided by a **Non-Participating Provider** that differs from the Copayment required for **Emergency Services** provided by a **Participating Provider** is hereby deleted and replaced with the Copayment requirement, if any, applicable to **Emergency Services** provided by **Participating Providers**.

   E. **Member Payments.** You are responsible for any applicable Copayment. We will ensure that you are held harmless for any **Non-Participating Provider** charges that exceed your Copayment.

2. **Preventive Services.** To the extent items and services in the sources referenced below are not already covered services for adults and children under the **HMO Certificate**, benefits for the items and services are hereby added to the **HMO Certificate**:

A. Items or services with an "A" or "B" rating from the United States Preventive Services Task Force;

B. Immunizations pursuant to the Advisory Committee on Immunization Practices ("ACIP") recommendations; and

C. Preventive care and screenings that are provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA").

The preventive services referenced above shall be covered in full when received from **Participating Providers**. Cost-sharing (e.g., Copayments) may apply to services provided during the same visit as the preventive services set forth above. For example, if a service referenced above is provided during an office visit wherein that service is not the primary purpose of the visit, the cost-sharing amount that would otherwise apply to the office visit will still apply.

A list of the preventive services covered under this paragraph is available on our website at www. Aetna.com, or will be mailed to you upon request. You may request the list by calling the Member Services number on your identification card.

3. **Access to OB/GYNs.** Any provision in the **HMO Certificate** that limits the number of visits you can make to a **Participating Provider** who specializes in obstetrics or gynecology without a referral from your **Primary Care Physician (PCP)** is hereby deleted in its entirety. You do not need prior authorization from us or from any other person (including a **PCP**) in order to obtain access to obstetrical or gynecological care from a **Participating Provider** who specializes in obstetrics or gynecology. The **Participating Provider**, 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 Providers** who specialize in obstetrics or gynecology, contact us at the Member Services number on your identification card.

4. **Choice of PCP. HMO** generally requires the designation of a **PCP**. You have the right to designate any **PCP** who participates in **HMO** network and who is available to accept you or your family members. For children, you may designate a pediatrician as a **PCP**. Until you make this designation, **HMO** will designate one for you. For information on how to select a **PCP**, and for a list of the **Participating PCPs**, contact **HMO** at the Member Services number on your identification card.

5. **Annual Limits.** Any annual dollar limit under the **HMO Certificate** that applies to **Essential Benefits**, whether such annual limit applies only to an **Essential Benefit** or includes **Essential Benefits** and other benefits, is hereby deleted. "**Essential Benefits**" means benefits covered under the **HMO Certificate** in at least the following categories: ambulatory care; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative care; laboratory services; preventive and wellness services and chronic disease management; pediatric services including oral and vision care; and any other services to the extent required in regulations issued pursuant to the Patient Protection and Affordable Care Act.

6. **Dependent Children Covered to Age 26**. If **HMO** makes coverage of dependents available, this Amendment applies to coverage of children as follows:

A. If you selected other than individual coverage, your children who are under the age of 26 may be covered under **HMO**. Coverage lasts until the child turns 26 years of age. Your children need not be financially dependent upon you for support or claimed as dependents on your tax return; residents of your household; enrolled as students; or unmarried. Children-in-law (spouses of children) and grandchildren are not covered under this Amendment.

Coverage for your child who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, or physical handicap and who became so incapable prior to attaining age 26 shall not terminate while your coverage remains in effect and

the child remains in such condition, if you submit proof of your child's incapacity within 31 days of Your child's attaining age 26.

B. "Children" include your natural children, a legally adopted child; a stepchild; and a child for whom you are the proposed adoptive parent and who is dependent upon you during the waiting period prior to the adoption period. Coverage lasts until the child turns 26 years of age.

C. A child chiefly dependent upon you for support and for whom you have been appointed the legal guardian by court order is covered. Coverage lasts until the child turns 26 years of age.

D. Coverage shall be provided for any unmarried dependent child, regardless of age, who is incapable of self-sustaining employment because of mental retardation, mental illness, or developmental disability as defined in the New York Mental Hygiene Law, or because of physical handicap and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate.

E. The provisions of any Amendment to the **HMO Certificate** that extends coverage for young adults through age 29 (for example, the provision requiring that the child be unmarried) shall remain in effect for children ages 26 through 29 and are not changed by provisions set forth above in this Paragraph 6 that apply to children under the age of 26.

7. **Rescission.** The provision in the Group Agreement regarding rescissions is hereby deleted and replaced with the following:

Rescission. We may rescind your coverage if you commit fraud or make an intentional misrepresentation of material fact.

8. **Other Provisions.** All of the terms, conditions, and limitations of the **HMO Certificate** to which this Amendment is attached also apply to this Amendment, except where they are specifically changed by this Amendment.

AETNA HEALTH INC.
(NEW YORK)

DIALYSIS TREATMENT AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

The Section **Limitations on Services** of the **General Provisions** is hereby replaced by the following;

Limitation on Services. Except in cases of (a) **Emergency Services,** (b) **Urgent Care**, (c) dialysis treatments rendered by an **Non-Participating Provider** located outside **HMO's Service Area** when a **Participating Provider** has issued a written order for such treatment, stating that in his or her opinion such treatment is **Medically Necessary**, or (d) 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**.

AETNA HEALTH INC.
(NEW YORK)

AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

Section **Extension of Benefits Upon Total Disability**, of the **HMO Certificate**, is replaced by the following:

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

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

  This extension of benefits shall only:

  1. commence when a **Medical Service** is rendered for the condition causing **Total Disability** while the **Member** is covered under this **Certificate**; and

  2. provide **Covered Benefits** that in effect under this **Certificate** on the date the **Member's** coverage under this **Certificate** end and are necessary to treat medical conditions causing or directly related to the disability as determined by **HMO**; and

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

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

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

     c. after a period of twelve (12) months in which benefits under such coverage are provided to the **Member**.

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

AETNA HEALTH INC.
(NEW YORK)

HMO AETNA OPEN ACCESS™ RIDER

Group Agreement Effective Date: January 1, 2013

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

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

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

The **PCP** provides services for the treatment of routine illnesses, injuries, well baby and preventive care services which do not require the services of a **Specialist**, and for non-office hour **Urgent Care** services under this plan. The **Member's** selected **PCP** or that **PCP's** covering **Physician** is required to be available 7 days a week, 24 hours a day for **Urgent Care** services.

A **Member** is required to select a **PCP** for themselves and for each of their **Covered Dependents** at the time of enrollment. A **Member** will be subject to the **PCP Copayment** listed on the Schedule of Benefits when a **Member** obtains **Covered Benefits** from their selected **PCP**. A **Member** may change their **PCP** at any time by contacting **HMO**.

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, the **Member** may also directly access **HMO Participating Providers** that are not affiliated to the IPA or PHO.

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

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

- **Self-Referred Services.**

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

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

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

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

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

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

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

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

- **Infertility** Program - Comprehensive **Infertility** Services are not covered without pre-authorization from **HMO's Infertility** unit, if such benefits are covered under the **Member's** plan. A **Member** or their **Participating Physician** may contact the **Infertility** unit to apply for eligibility. A **Member** who is eligible for the program 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.

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

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

AETNA HEALTH INC.
(NEW YORK)
DOMESTIC PARTNER RIDER

Contract Holder Group Agreement Effective Date: January 1, 2013

The Domestic Partner rider for this contract is effective January 1, 2013

Subsection A.2.a of the Eligibility and Enrollment section of the **Certificate** is hereby deleted and replaced with the following:

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

i. provides proof of cohabitation (e.g. driver's license or tax return);
ii. are both of the age of consent in their state of residence;
iii. are not related by blood in any manner that would bar marriage in their state of residence;
iv. have a close, committed and monogamous personal relationship;
v. have been sharing the same household on a continuous basis for at least 6 months;
vi. have registered as domestic partners where such registration is available;
vii. is not married to, or separated from, another individual;
viii. have not been registered as a member of another domestic partnership within the last 6 months; and
ix. demonstrates financial interdependence by submission of proof of 3 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.
(NEW YORK)

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.
(NEW YORK)

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 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.

- **Drug Formulary**. A list of prescription drugs 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, whether identified by its 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.

- **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 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**.

- **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 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.** Certain outpatient prescription drugs require precertification. 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 also be available upon request by the **Member** or may be accessed at the pharmacy website, at www.aetna.com.

- **Self-injectable Drug(s)**. Prescription drugs that are self-administered by injection.

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

- **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.

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 are covered when prescribed by a **Provider** licensed to prescribe federal legend prescription drugs or medicines subject to the terms, **HMO** policies, Exclusions and Limitations section described in this rider and the **Certificate**. Coverage is based on **HMO's** or an affiliate's determination, in its sole discretion, if a prescription drug is covered. Some items are covered only with pre-authorization from **HMO**. Items covered by this rider are subject to drug utilization review by **HMO** and/or **Member's Participating Provider** and/or **Member's Participating Retail** or **Mail Order Pharmacy**.

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

C. FDA approved prescription drugs are covered when the off-label use of the drug has not been approved by the FDA for that indication, provided that such drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information), or the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer reviewed journal. Coverage of off label use of these drugs may, in **HMO's** sole discretion, be subject to the **Precertification Program**, the **Step Therapy Program,** or other **HMO** requirements or limitations. Subsequent to the final determination of the external review process, experimental or investigational drugs will be covered as required.

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:

- **Infertility Drugs.** These include, and are subject to change by **HMO** or an affiliate, urofollitropin, menotropin, human chorionic gonadotropin, progesterone and Injectable **Infertility Drugs** used to treat **Infertility**. Coverage is only provided for drugs used in the treatment of a covered infertility medical service as outlined in the **Certificate**.

- **Self-injectable Drugs.**

  Self-injectable Drugs 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 **Participating Mail Order Pharmacy or Specialty Pharmacy Network** pharmacy. With the following exceptions, the **Member** is required to obtain all covered Self-Injectable Drugs at a **Specialty Pharmacy Network Pharmacy**:

  Exceptions:
  Blood thinners (Arixtra, Fragmin, Innohep, Lovenox, Orgaran)
  Diabetic drugs (Insulin, Byetta, Glucagon, Symlin)
  Emergency Medications (Epinephrine Kits)
  Erectile Dysfunction Medications (Caverject, Edex)
  Migraine Medications (Imitrex)
  Multiple Sclerosis Medications (Betaseron)

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** 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 this Prescription Plan Rider.

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.

Triple Copayment Options:

Generic Formulary Prescription Drug or Medicine	**Brand Name Formulary Prescription Drug or Medicine**	**Non-Formulary Prescription Drug or Medicine**
Copayment	**Copayment**	**Copayment**
$10	**$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.
2. Any drug determined not to be **Medically Necessary** for the treatment of disease or injury unless otherwise covered under this rider.
3. **Cosmetic Surgery**, except that **Cosmetic Surgery** shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a **Covered Dependent** child which has resulted in a functional defect.

4. Needles and syringes, except as otherwise covered in the **Certificate**.
5. 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**.
6. 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.
7. Drugs used for the purpose of weight reduction (e.g., appetite suppressants), including the treatment of obesity, unless **Medically Necessary**, as determined by **HMO**.
8. 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.
9. 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.
10. Drugs prescribed for uses other than uses approved by the Food and Drug Administration (FDA) under the Federal Food, Drug and Cosmetic Law and regulations, or any drug labeled "Caution: Limited by Federal Law to Investigational Use", or experimental drugs except as otherwise covered under this rider. Subsequent to the final determination of the external review process, experimental and investigational drugs will be covered as required.
11. Medical supplies, devices and equipment and non-medical supplies or substances regardless of their intended use except as otherwise covered in the **Certificate**. Bone mineral density devices are not included in this exclusion.
12. Test agents and devices, including but not limited to diabetic test agents.
13. Injectable drugs used for in vitro fertilization (IVF), gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT).
14. Injectable drugs, except as otherwise covered in the **Certificate**.
15. Prescription orders filled prior to the effective date or after the termination date of the coverage provided by this rider.
16. Replacement for lost or stolen prescriptions.
17. Performance and athletic performance drugs and supplies, unless **Medically Necessary**.
18. 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.
19. 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.
20. Medication packaged in unit dose form. (Except those products approved for payment by **HMO)**.
21. Prophylactic drugs for travel.
22. Drugs recently approved by the FDA, but which have not yet been reviewed by the Aetna Health Inc. Pharmacy Management Department and Therapeutics Committee, except when approved through the medical exceptions process.
23. 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.
24. Nutritional supplements.
25. Injectable drugs, except for **Self-injectable Drugs**.

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 Claim Procedures/Complaints and Appeals section of the **Certificate**.

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

4. The **Copayment** for diabetic equipment, supplies and insulin covered under the **Certificate** will be the **Copayment** listed on the Schedule of Benefits for the **PCP** visit.

5. The grievance and appeal process, including the external appeal process, is described in detail in the **Certificate**.

6. **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 for any drug for which no charge is made to the recipient.

7. The Continuation and Conversion section 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.
(NEW YORK)

PRESCRIPTION PLAN CONTRACEPTIVES RIDER

Group Agreement Effective Date: January 1, 2013

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

Contraceptives.

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

1. Oral Contraceptives.
2. Diaphragms.
3. Injectable contraceptives.
4. Contraceptive patches.
5. Contraceptive rings.
6. Norplant and IUDs are covered when obtained from a **Participating Provider**. The **Participating Provider** 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).

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

The conversion privilege does not apply to the **HMO** Prescription Drug Contraceptive Rider.

AETNA HEALTH INC.
(NEW YORK)

PRESCRIPTION PLAN RIDER AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The following provision is added to Section G. Copayments of the Prescription Plan Rider.

In no event will a prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells have a higher cost-sharing than an intravenous or injected anticancer medication under the Certificate of Coverage.

AETNA HEALTH INC.
(NEW YORK)

SCHEDULE OF BENEFITS

CHARTER OPEN ACCESS PLAN
Government of the District of Columbia
Contract Holder Group Agreement Effective Date: January 1, 2013
Contract Holder Number: 172614
Contract Holder Locations: 038
Contract Holder Service Areas: GN01

BENEFITS

Benefit	Maximums
Maximum Out-of-Pocket Limit	**$3,500 per Member per calendar year**
	$10,500 per family per calendar year

The family **Maximum Out-of-Pocket Limit** is a cumulative **Maximum Out-of-Pocket Limit** for all family members.

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

OUTPATIENT BENEFITS

Benefit	Copayment
Primary Care Physician Services	
Adult Physical Examination	**$0 per visit**
Well Child Physical Examination including Immunizations	**$0 per visit**
Office Hours Visits	**$10 per visit**
After-Office Hours and Home Visits	**$15 per visit**
Routine Gynecological Exam(s) 2 visits per calendar year	**$0 per visit**
Specialist Physician Services	
Office Visits	**$20 per visit**
First OB Visit	**$0**
Outpatient Rehabilitation	
Treatment over a 60 consecutive day period per incident of illness or injury beginning with the first day of treatment	**$20 per visit**
Outpatient Facility Visits	**$20 per visit**
Chemotherapy	**$20 per visit**
Hemodialysis	**$20 per visit**

Diagnostic X-Ray Testing	**$20 per visit**
Diagnostic Laboratory Testing	**$0 per visit**
Mammography (Diagnostic)	**$20 per visit**
Subluxation Unlimited visits per 365 day period	**$20 per visit**
Outpatient Emergency Services Hospital Emergency Room or Outpatient Department	**$50 per visit (waived if admitted)**
Urgent Care Facility	**$35 per visit**
Ambulance	**$0 per trip**
Outpatient Mental Health Visits **Unlimited visits per calendar year**	**$10 per visit**
Outpatient Substance Abuse Visits Detoxification	**$10 per visit/day**
Outpatient Substance Abuse Visits Rehabilitation: Unlimited visits per calendar year, of which up to 20 visits may be used for family members**.**	**$10 per visit/day**
Outpatient Surgery Facility	**$50 per visit**
Outpatient Home Health Visits Limited to 3 intermittent visit(s) per day provided by a **Participating** home health care agency; 1 visit equals a period of 4 hours or less. Unlimited visits per calendar year	**$0 per visit**
Outpatient Hospice Care Visits Hospice Bereavement Counseling: 5 visits per 365-day period	**$0 per visit**
Injectable Medications	**$10 per visit or per prescription or refill**

INPATIENT BENEFITS

Benefit	**Copayment**
Acute Care	**$100 per Continuous Confinement**
Mental Health Maximum of Unlimited days per calendar year	**$100 per Continuous Confinement.**
Substance Abuse Detoxification	**$100 per Continuous Confinement.**

Substance Abuse Rehabilitation: Maximum of Unlimited days per calendar year	**$100 per Continuous Confinement**
Maternity	**$100 per Continuous Confinement**
Skilled Nursing Facility Maximum of 60 days per calendar year	**$100 per Continuous Confinement (waived if a Member is transferred from a Hospital to a Skilled Nursing Facility)**
Hospice Care Hospice Bereavement Counseling: 5 visits per 365-day period	**$0 per Continuous Confinement (waived if a Member is transferred from a Hospital to a Hospice Care Facility)**

ADDITIONAL BENEFITS

Benefit	**Copayment**
Eye Examination by a Specialist (including refraction) as per schedule in the Certificate	**$20 per visit**
Durable Medical Equipment (DME)	**50% (of the cost) per item**
Counts toward the Member's medical Maximum Out-of-Pocket Limit	
DME Maximum Benefit	**Unlimited per Member, per calendar year**

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

Eligible for benefits on the date of hire.

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

i. under 26 years of age; or

ii. under 26 years of age, dependent on a parent or guardian **Member**, and attending a recognized college or university, trade or secondary school on a full-time basis; or

iii. chiefly dependent upon the **Subscriber** for support and maintenance, and is 26 years of age or older but incapable of self-support due to mental or physical incapacity, either of which commenced prior to: 26, or if a student, 26.

If the student is on a leave of absence due to illness and a licensed medical practitioner certifies the **Medical Necessity** of the leave of absence, coverage will be extended for one year following the last day of attendance, subject to the age limitations listed on the Schedule of Benefits

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.