

**AETNA HEALTH INC.
(DISTRICT OF COLUMBIA)**

**1301 McCormick Drive
Largo, Maryland 20774
(301) 636-0000**

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 District of Columbia.

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.

<p>Contract Holder: GOVERNMENT OF THE DISTRICT OF COLUMBIA Contract Holder Number: 0866123 Contract Holder Group Agreement Effective Date: January 01, 2014</p>
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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 a **Participating Provider**. The **PCP** can also order lab tests and x-rays, prescribe medicines or therapies, and arrange hospitalization.

A **Member** may receive a standing **Referral** from their **PCP** to a **Participating Specialist** if the **Member** has a chronic, disabling or life-threatening condition that requires specialized medical care over a prolonged period of time, and after consulting with their **PCP**, they select a **Participating Specialist** who is responsible for and capable of providing and coordinating their primary and specialty care. During the treatment period authorized by the **Referral**, such **Participating Specialist** shall be permitted to treat the **Member** without a further **Referral** from the **Member's PCP** and to authorize such **Referrals**, procedures, tests and other medical services related to the **Member's** condition as the **Member's PCP** would otherwise be permitted to provide or authorize under this **Certificate**. The standing **Referral** shall be made in accordance with a written plan for **Covered Benefits** developed by the **PCP, Participating Specialist, and Member**.

In certain other 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.

Except for a **Medical Emergency, Urgent Care** service 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**.

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. Except when a **Provider** is terminated for cause, if a **Member** is undergoing a course of treatment from a **Provider** when the **Provider's** participation in the **HMO's Participating Provider** network terminates, **HMO** will notify the **Member** on a timely basis of the termination and cover services and supplies that are **Covered Benefits** provided by the **Provider** to the **Member**:

1. for a period of at least 90 days from the date of the notice of the **Provider's** termination if the **Member** was in an active course of treatment with the **Provider** prior to the notice of termination and the **Member** requested to continue to receive **Covered Benefits** from the **Provider**.
2. at the **Member's** option, for a period of at least 90days from the date of the notice of the **Provider's** termination if the **Member** had entered their second trimester of pregnancy at the time of the **Provider's** termination of participation.

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 Grievance Procedure 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

A **Member** will be entitled to **Covered Benefits** after the **Member** has satisfied the **Deductible** amount, if any, specified on the Schedule of Benefits. After satisfying the **Deductible**, the **Member** must pay any applicable **Copayment** for **Covered Benefits**. The **Deductible** does not apply to certain **Covered Benefits**. **Covered Benefits** to which the **Deductible** applies are shown in the Schedule of Benefits. The **Member** must pay any applicable **Copayments** for **Covered Benefits** to which the **Deductible** does not apply.

The Deductible.

The **Deductible** applies to each **Member**, subject to any family **Deductible** listed on the Schedule of Benefits. For purposes of the **Deductible**, "family" means the **Subscriber** and **Covered Dependents**. The **Deductible** must be satisfied once each **calendar year**, except for:

- the Common Accident Provision: if the **Deductible** applies to accident expenses and if 2 or more members of 1 family receive **Covered Benefits** because of disabilities resulting from injuries sustained in any 1 accident, the **Deductible** will be applied only once with respect to all **Covered Benefits** received as a result of the accident.

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. **Covered Benefits** applied toward satisfaction of the **Deductible** will be counted toward any applicable visit or day maximums for **Covered Benefits** under this **Certificate**.

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

5. Notification of Change in Status.

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

6. Special Enrollment Period.

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

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

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

- a. the eligible individual or the eligible dependent was covered under another group health plan or other health insurance coverage when initially eligible for coverage under **HMO**;
- b. the eligible individual or eligible dependent declines coverage in writing under **HMO**;
- c. the eligible individual or eligible dependent loses coverage under the other group health plan or other health insurance coverage for 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 a loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing.

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

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

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

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

Special Enrollment Period When a New Eligible Dependent is Acquired:

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

The special enrollment period is a period of 30 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**.

7. Late Enrollment.

Eligible individuals and their dependents may also be enrolled at any other time upon submission of complete enrollment information and payment of **Premium** to **HMO**. Coverage shall not become effective until confirmed, in writing, by **HMO**.

C. **Effective Date of Coverage.**

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

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

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

COVERED BENEFITS

A **Member** shall be entitled to the **Covered Benefits** as specified below, in accordance with the terms and conditions of this **Certificate**. Unless specifically stated otherwise, in order for benefits to be covered, they must be **Medically Necessary**. For the purpose of coverage, **HMO** may determine whether any benefit provided under the **Certificate** is **Medically Necessary**, and **HMO** has the option to only authorize coverage for a **Covered Benefit** performed by a particular **Provider**. Preventive care, as described below, will be considered **Medically Necessary**.

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

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

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

- be care or services related to diagnosis or treatment of an existing illness or injury, except for covered periodic health evaluations and preventive and well baby care, as determined by **HMO**;
- be a diagnostic procedure, indicated by the health status of the **Member** and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the **Member's** overall health condition;
- include only those services and supplies that cannot be safely and satisfactorily provided at home, in a **Physician's** office, on an outpatient basis, or in any facility other than a **Hospital**, when used in relation to inpatient **Hospital** services; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests.

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

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

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

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

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

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

A. Primary Care Physician Benefits.

1. Office visits during office hours.
2. Home visits.

3. After-hours **PCP** services. **PCPs** are required to provide or arrange for on-call coverage 24 hours a day, 7 days a week. If a **Member** becomes sick or is injured after the **PCP's** regular office hours, the **Member** should:
 - a. call the **PCP's** office;
 - b. identify himself or herself as a **Member**; and
 - c. follow the **PCP's** or covering **Physician's** instructions.

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

4. **Hospital** visits.
5. Periodic health evaluations to include:
 - a. well child care from birth including immunizations and booster doses of all immunizing agents used in child immunizations which conform to the standards of the Advisory Committee on Immunization Practices of the Centers for Disease Control, U.S. Department of Health and Human Services;
 - b. routine physical examinations;
 - c. routine gynecological examinations, including Pap smears, for routine care, administered by the **PCP**. The **Member** may also go directly to a **Participating** gynecologist without a **Referral** for routine GYN examinations and Pap smears. See the Direct Access Specialist Benefits section of this **Certificate** for a description of these benefits;
 - d. routine hearing screenings;
 - e. immunizations (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.

B. Diagnostic Services Benefits.

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

1. Diagnostic, laboratory, and x-ray services.
2. Mammograms, by a **Participating Provider**. The **Member** is required to obtain a **Referral** from her **PCP** or gynecologist, or obtain pre-authorization from **HMO** to a **Participating Provider**.

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

- age 40 and older, 1 routine mammogram every year; or
- when **Medically Necessary**.

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 a **HMO** Medical Director and an appropriate **Specialist** determines that a standing **Referral** is warranted, the **PCP** shall make the **Referral** to a **Specialist**. This standing **Referral** shall be pursuant to a treatment plan approved by the **HMO** Medical Director in consultation with the **PCP**, **Specialist** and **Member**.

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

D. **Direct Access Specialist Benefits.**

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

- Routine Gynecological Examination(s). Routine gynecological visit(s) and Pap smear(s). The maximum number of visits, if any, is listed on the Schedule of Benefits.
- Direct Access to Gynecologists. Benefits are provided to female **Members** for services performed by a **Participating** gynecologist for diagnosis and treatment of gynecological problems. See the **Infertility** Services section of this **Certificate** for a description of covered **Infertility** services.
- Routine Eye Examinations, including refraction, as follows:
 1. if **Member** is age 1 through 18 and wears eyeglasses or contact lenses, 1 exam every 24 Months period.
 2. if **Member** is age 19 and over and wears eyeglasses or contact lenses, 1 exam every 24 Months period.
 3. if **Member** is age 1 through 45 and does not wear eyeglasses or contact lenses, 1 exam every 24 Months period.
 4. if **Member** is age 46 and over and does not wear eyeglasses or contact lenses, 1exam every 24 Months period.

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

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

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

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

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

2. a minimum of 96 hours of inpatient care in a **Participating Hospital** following a cesarean section;
or
3. a shorter **Hospital** stay, if requested by a mother, and if determined to be medically appropriate by the **Participating Providers** in consultation with the mother.

F. Inpatient Hospital and Skilled Nursing Facility Benefits.

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

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

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

G. Transplants.

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

H. Outpatient Surgery Benefits.

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

I. Substance Abuse Benefits.

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

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

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

2. Inpatient care benefits are covered for **Detoxification**. Benefits include medical treatment and referral services for **Substance Abuse** or addiction. The following services shall be covered under inpatient treatment: lodging and dietary services; **Physicians**, psychologist, nurse, certified

addictions counselor and trained staff services; diagnostic x-ray; psychiatric, psychological and medical laboratory testing; and drugs, medicines, equipment use and supplies.

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

J. Mental Health Benefits.

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

1. Outpatient benefits are covered for short-term, outpatient evaluative and crisis intervention or home health mental health services, and are subject to the maximum number of visits, if any, shown on the Schedule of Benefits.
2. Inpatient benefits may be covered for medical, nursing, counseling or therapeutic services in an inpatient, **Hospital** or non-hospital residential facility, appropriately licensed by the Department of Health or its equivalent. Coverage, if applicable, is subject to the maximum number of days, if any, shown on the Schedule of Benefits.

K. Emergency Care/Urgent Care Benefits.

1. **Emergency Care:**

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

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

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

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

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.

L. Rehabilitation Benefits.

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

1. A limited course of cardiac rehabilitation following an inpatient **Hospital** stay is covered when **Medically Necessary** following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
2. Pulmonary rehabilitation following an inpatient **Hospital** stay is covered when **Medically Necessary** for the treatment of reversible pulmonary disease states.
3. Cognitive therapy associated with physical rehabilitation is covered for non-chronic conditions and acute illnesses and injuries as part of a treatment plan coordinated with **HMO**. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.
4. Physical therapy is covered for non-chronic conditions and acute illnesses and injuries. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.
5. Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute illnesses. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.
6. Speech therapy is covered for non-chronic conditions and acute illnesses and injuries and is subject to the limits, if any, shown on the Schedule of Benefits. Services rendered for the treatment of delays in speech development, unless resulting from disease, injury, or congenital defects, are not covered.

M. Home Health Benefits.

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

1. Skilled nursing services for a **Homebound Member**. Treatment must be provided by or supervised by a registered nurse.
2. Services of a home health aide. These services are covered only when the purpose of the treatment is **Skilled Care**.

3. Medical social services. Treatment must be provided by or supervised by a qualified medical **Physician** or social worker, along with other **Home Health Services**. The **PCP** must certify that such services are necessary for the treatment of the **Member's** medical condition.
4. Short-term physical, speech, or occupational therapy is covered. Coverage is limited to those conditions and services under the Outpatient Rehabilitation Benefits section of this **Certificate**.

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

N. Hospice Benefits.

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

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

O. Prosthetic Appliances.

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

P. Injectable Medications.

Injectable medications, including those medications intended to be self administered, are a **Covered Benefit** when an oral alternative drug is not available, unless specifically excluded as described in the Exclusions and Limitations section of this **Certificate**. Medications must be prescribed by a **Provider** licensed to prescribe federal legend prescription drugs or medicines, and pre-authorized by **HMO**. If the drug therapy treatment is approved for self-administration, the **Member** is required to obtain covered medications at an **HMO Participating** pharmacy designated to fill injectable prescriptions.

Injectable drugs or medication used for the treatment of cancer or HIV are covered when the off-label use of the drug has not been approved by the FDA for that indication, provided that such drug is recognized for treatment of such indication in 1 of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) and the safety and effectiveness of use for this indication has been adequately demonstrated by at least 1 study published in a nationally recognized peer reviewed journal.

Q. Reconstructive Breast Surgery

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.

R. Diabetic Supplies, Equipment and Self-Management Training and Education.

Medically Necessary diabetic equipment and supplies and diabetic outpatient self-management training and educational services, including medical nutrition therapy are covered when ordered or prescribed by and obtained through a **Participating Provider** for the treatment of the following diabetic conditions:

- Insulin-dependent diabetes;
- Insulin-using diabetes;
- Gestational diabetes; and
- Non-insulin using diabetes

S. Colorectal Cancer Screening

Colorectal cancer screening services, that are in compliance with the American Cancer Society's colorectal cancer screening guidelines and are current at the time the services are rendered, are covered when ordered or prescribed by and obtained through a **Participating Provider**.

T. Additional Benefits.

- **Subluxation Benefits.**

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

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

- **Durable Medical Equipment Benefits.**

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

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

1. it is needed due to a change in the **Member's** physical condition; or
2. it is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment.

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

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

EXCLUSIONS AND LIMITATIONS

A. Exclusions.

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

- Ambulance services, for routine transportation to receive outpatient or inpatient services.
- Beam neurologic testing.
- Biofeedback, except as pre-authorized by **HMO**.
- Blood and blood plasma, including but not limited to, provision of blood, blood plasma, blood derivatives, synthetic blood or blood products other than blood derived clotting factors, the collection or storage of blood plasma, the cost of receiving the services of professional blood donors, apheresis or plasmapheresis. Only administration, processing of blood, processing fees, and fees related to autologous blood donations are covered.
- Care for conditions that state or local laws require to be treated in a public facility, including but not limited to, mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- **Cosmetic Surgery**, or treatment relating to the consequences of, or as a result of, **Cosmetic Surgery**, other than **Medically Necessary Services**. This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty, except when determined to be **Medically Necessary** by an **HMO** Medical Director, is not covered. This exclusion does not apply to surgery to correct the results of injuries causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.
- Costs for services resulting from the commission of, or attempt to commit a felony by the **Member**.
- Court ordered services, or those required by court order as a condition of parole or probation.
- **Custodial Care**.
- Dental services, including but not limited to, services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, dental services related to the gums, apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, alveolectomy, augmentation and vestibuloplasty treatment of periodontal disease, false teeth, prosthetic restoration of dental implants, and dental implants. This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors, and orthodontogenic cysts.

- Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, learning disabilities, or developmental delays. Special education, including lessons in sign language to instruct a **Member**, whose ability to speak has been lost or impaired, to function without that ability, are not covered.
- **Experimental or Investigational Procedures**, or ineffective surgical, medical, psychiatric, or dental treatments or procedures, research studies, or other experimental or investigational health care procedures or pharmacological regimes as determined by **HMO**, unless pre-authorized by **HMO**.

This exclusion will not apply with respect to drugs:

1. that have been granted treatment investigational new drug (IND) or Group c/treatment IND status;
 2. that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or
 3. **HMO** has determined that available scientific evidence demonstrates that the drug is effective or the drug shows promise of being effective for the disease.
- Hair analysis.
 - Hearing aids.
 - Home births.
 - Home uterine activity monitoring.
 - Household equipment, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, whirlpool or swimming pools, exercise and massage equipment, central or unit air conditioners, air purifiers, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a **Member's** house or place of business, and adjustments made to vehicles.
 - Hypnotherapy, except when pre-authorized by **HMO**.
 - Implantable drugs.
 - **Infertility** services not explicitly covered, as provided in the Covered Benefits section of this **Certificate**. This exclusion includes, but is not limited to:
 1. Services for couples in which one of the partners has had a previous sterilization procedure, with or without reversal;
 2. Services for females with FSH levels greater than 19 mIU/ml on Day 3 of the menstrual cycle;
 3. The purchase of donor sperm and any charges for the storage of sperm;
 4. The purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers;

5. Charges associated with cryopreservation or storage of cryopreserved embryos (e.g., office, **Hospital**, ultrasounds, laboratory tests, etc.);
 6. Artificial Insemination for females without male partners attempting to become pregnant who have not had at least 12 cycles of donor insemination (6 cycles for **Members** age 35 or older) prior to enrolling in **HMO's Infertility** program;
 7. Any service provided by a non-participating **Provider** or, in the case of Comprehensive **Infertility** Services, without a prior **Referral** or claim authorization from **HMO's Infertility** program case management unit;
 8. Home ovulation prediction kits;
 9. Drugs related to the treatment of non-covered benefits or related to the treatment of **Infertility** that are not **Medically Necessary**;
 10. Injectable **Infertility** medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
 11. Any advanced reproductive technology ("ART") procedures or services related to such procedures, including but not limited to in vitro fertilization (IVF), gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), and intracytoplasmic sperm injection (ICSI);
 12. Any charges associated with care required for ART (e.g., office, **Hospital**, ultrasounds, laboratory tests, etc.);
 13. Donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
 14. Any charges associated with a frozen embryo transfer, including but not limited to thawing charges;
 15. Reversal of sterilization surgery; and
 16. Any charges associated with obtaining sperm for any ART procedures.
- Military service related diseases, disabilities or injuries for which the **Member** is legally entitled to receive treatment at government facilities and which facilities are reasonably available to the **Member**.
 - Missed appointment charges.
 - Non-medically necessary services, including but not limited to, those services and supplies:
 1. which are not **Medically Necessary**, as determined by **HMO**, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services;
 2. that do not require the technical skills of a medical, mental health or a dental professional;

3. furnished mainly for the personal comfort or convenience of the **Member**, or any person who cares for the **Member**, or any person who is part of the **Member's** family, or any **Provider**;
 4. furnished solely because the **Member** is an inpatient on any day in which the **Member's** disease or injury could safely and adequately be diagnosed or treated while not confined;
 5. furnished solely because of the setting if the service or supply could safely and adequately be furnished in a **Physician's** or a dentist's office or other less costly setting.
- Orthotics.
 - Outpatient supplies, including but not limited to, medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings, and reagent strips.
 - Payment for that portion of the benefit for which Medicare or another party is the primary payer.
 - Personal comfort or convenience items, including those services and supplies not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other like items and services.
 - Prescription or non-prescription drugs and medicines, except as provided on an inpatient basis.
 - Private duty or special nursing care, unless pre-authorized by **HMO**.
 - Recreational, educational, and sleep therapy, including any related diagnostic testing.
 - Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling, and sex therapy.
 - Reversal of voluntary sterilizations, including related follow-up care and treatment of complications of such procedures.
 - Routine foot/hand care, including routine reduction of nails, calluses and corns.
 - Services for which a **Member** is not legally obligated to pay in the absence of this coverage.
 - Services for the treatment of sexual dysfunctions or inadequacies, including therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
 - Services, including those related to pregnancy, rendered before the effective date or after the termination of the **Member's** coverage, unless coverage is continued under the Continuation and Conversion section of this **Certificate**.
 - Services performed by a relative of a **Member** for which, in the absence of any health benefits coverage, no charge would be made.
 - Services required by third parties, including but not limited to, physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state, or federal government, securing insurance coverage, travel, school admissions or attendance, including examinations required to participate in athletics, except when such examinations are considered to be part of an appropriate schedule of wellness services.

- Services which are not a **Covered Benefit** under this **Certificate**, even when a prior **Referral** has been issued by a **PCP**.
- Specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
- Specific injectable drugs, including:
 1. experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the Food and Drug Administration (FDA) and the National Institutes of Health (NIH);
 2. needles, syringes and other injectable aids;
 3. drugs related to the treatment of non-covered services; and
 4. drugs related to the treatment of **Infertility**, contraception, and performance enhancing steroids.
- Special medical reports, including those not directly related to treatment of the **Member**, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
- Surgical operations, procedures or treatment of obesity, except when pre-authorized by **HMO**.
- Therapy or rehabilitation, including but not limited to, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, vision perception training, and carbon dioxide.
- Thermograms and thermography.
- Transsexual surgery, sex change or transformation, including any procedure or treatment or related service designed to alter a **Member's** physical characteristics from the **Member's** biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.
- Treatment in a federal, state, or governmental entity, including care and treatment provided in a non-participating **Hospital** owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.
- Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded **Members** in accordance with the benefits provided in the Covered Benefits section of this **Certificate**.
- Treatment of occupational injuries and occupational diseases, including those injuries that arise out of (or in the course of) any work for pay or profit, or in any way results from a disease or injury which does. If a **Member** is covered under a Workers' Compensation law or similar law, and submits proof that the **Member** is not covered for a particular disease or injury under such law, that disease or injury will be considered "non-occupational" regardless of cause.
- Unauthorized services, including any service obtained by or on behalf of a **Member** without a **Referral** issued by the **Member's PCP** or pre-authorized by **HMO**. This exclusion does not apply in a **Medical Emergency**, in an **Urgent Care** situation, or when it is a direct access benefit.

- Vision care services and supplies, including orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) and radial keratotomy, including related procedures designed to surgically correct refractive errors.
- Weight reduction programs, or dietary supplements.
- Acupuncture and acupuncture therapy, except when performed by a **Participating Physician** as a form of anesthesia in connection with covered surgery.
- Family planning services.
- Temporomandibular joint disorder treatment (TMJ), including but not limited to, treatment performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutics services related to TMJ.

B. Limitations.

- In the event there are 2 or more alternative **Medical Services** which in the sole judgment of **HMO** are equivalent in quality of care, **HMO** reserves the right to provide coverage only for the least costly **Medical Service**, as determined by **HMO**, provided that **HMO** pre-authorizes the **Medical Service** or treatment.
- Determinations regarding eligibility for benefits, coverage for services, benefit denials and all other terms of this **Certificate** are at the sole discretion of **HMO**, subject to the terms of this **Certificate**.

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

TERMINATION OF COVERAGE

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

A. Termination of Subscriber Coverage.

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

1. employment terminates;
2. the **Group Agreement** terminates;
3. the **Subscriber** is no longer eligible as outlined in this **Certificate** and/or on the Schedule of Benefits; or
4. the **Subscriber** becomes covered under an alternative health benefit plan or under any other plan which is offered by, through, or in connection with, the **Contract Holder** in lieu of coverage under this **Certificate**.

B. Termination of Dependent Coverage.

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

1. a **Covered Dependent** is no longer eligible, as outlined in this **Certificate** and/or on the Schedule of Benefits;
2. the **Group Agreement** terminates; or
3. the **Subscriber's** coverage terminates.

C. Termination For Cause.

HMO may terminate coverage for cause:

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

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

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

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

CONTINUATION AND CONVERSION

A. COBRA Continuation Coverage.

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

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

1. Minimum Size of Group:

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

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

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

3. Loss of coverage due to:

- a. divorce or legal separation, or
- b. **Subscriber's** death, or
- c. **Subscriber's** entitlement to Medicare benefits, or,
- d. cessation of **Covered Dependent** child status under the Eligibility and Enrollment section of this **Certificate**:

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

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

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

- b. the last day of the 36 month period.
 - c. the first day on which timely payment of **Premium** is not made subject to the Premiums section of the **Group Agreement**.
 - d. the first day on which the **Contract Holder** ceases to maintain any group health plan.
 - e. the first day, after the day COBRA coverage has been elected, on which a **Member** is actually covered by any other group health plan. In the event the **Member** has a preexisting condition, and the **Member** would be denied coverage under the new plan for a preexisting condition, continuation coverage will not be terminated until the last day of the continuation period, or the date upon which the **Member's** preexisting condition becomes covered under the new plan, whichever occurs first.
 - f. the date, after COBRA coverage has been elected, when the **Member** is entitled to Medicare.
5. Extensions of Coverage Periods:
- a. The 18 month coverage period may be extended if an event which would otherwise qualify the **Member** for the 36 month coverage period occurs during the 18 month period, but in no event may coverage be longer than 36 months from the event which qualified the **Member** for continuation coverage initially.
 - b. In the event that a **Member** is determined, within the meaning of the Social Security Act, to be disabled and notifies the **Contract Holder** within 60 days of the Social Security determination and before the end of the initial 18 month period, continuation coverage for the **Member** and other qualified beneficiaries may be extended up to an additional 11 months for a total of 29 months. The **Member** must have become disabled during the first 60 days of the COBRA continuation coverage.
6. Responsibility of the **Contract Holder** to provide **Member** with notice of Continuation Rights:
- The **Contract Holder** is responsible for providing the necessary notification to **Members**, within the defined time period, as required by COBRA.
7. Responsibility to pay **Premiums** to **HMO**:
- The **Subscriber** or **Member** will only have coverage for the 60 day initial enrollment period if the **Subscriber** or **Member** pays the applicable **Premium** charges due within 45 days of submitting the application to the **Contract Holder**.
8. **Premiums** due **HMO** for the continuation of coverage under this section shall be due in accordance with the procedures of the Premiums section of the **Group Agreement** and shall be calculated in accordance with applicable federal law and regulations.

B. Continuation Coverage Under District of Columbia Laws.

The Continuation of Health Coverage Emergency Act of 2001 permits **Subscribers** or **Covered Dependents** to elect to continue group coverage if:

1. Size of Group:

The **Contract Holder** that employed the **Subscriber** employed more than one (1) but less than twenty (20) employees on a typical business day during the preceding calendar year. This refers

to the number of employees employed, not the number of employees covered by a health plan, and includes full-time and part-time employees.

2. **Subscriber:**

- a. Lost coverage due to termination (other than for gross misconduct);
- b. Is not eligible for continuation of coverage under COBRA; and
- c. Completed the timely election (application) of and payment for coverage as described below.

3. **Covered Dependent** lost coverage due to:

- a. **Subscriber's** loss of coverage as described in Section B.2 above; or
- b. cessation of the **Covered Dependent's** child status under the Eligibility and Enrollment section of this **Certificate**:

The **Member** may elect to continue coverage for 3 months after eligibility for coverage under this **Certificate** would otherwise cease.

Continuation coverage ends at the earliest of the following events:

1. the last day of the 3-month period;
2. the first day on which timely payment of **Premium** is not made subject to the Premiums section of the **Group Agreement**;
3. the first day on which the **Contract Holder** ceases to maintain any group health plan;
4. the **Member** establishes residence outside the **HMO Service Area**;
5. the first day on which the **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; or
6. the date the **Member** is entitled to Medicare.

Responsibility to provide **Member** with notice of Continuation Rights

The **Contract Holder** is responsible for providing the necessary notification to **Members** of the right to continue coverage under this act, within fifteen (15) days after the date the **Member's** coverage would otherwise terminate. Failure of the **Contract Holder** to furnish notice to the **Member** will not extend the right to continue coverage beyond the time provided under this act.

Responsibility to enroll and pay **Premiums** to **HMO**

Coverage for the period of time required to initially enroll, will be extended only where the **Subscriber** or **Member** applies for the continuation coverage and pays the applicable **Premium** charges due to the **Contract Holder** and **Contract Holder** in turn remits same to **HMO**, within forty-five (45) days of the date the **Member's** coverage would otherwise terminate.

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 laws and regulations, and shall not exceed 102% of the **Contract Holder's** group **Premium** rate.

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

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

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

D. **Conversion Privilege.**

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

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

1. Eligibility.

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

- a. coverage under this **Certificate** was terminated, and was not replaced with continuous and similar coverage by the **Contract Holder**;
- b. the **Subscriber** ceased to meet the eligibility requirements as described in this **Certificate** and on the Schedule of Benefits, in which case the **Subscriber** and **Subscriber's** dependents who are **Members** pursuant to this **Certificate**, if any, are eligible to convert;

- c. a **Covered Dependent** ceased to meet the eligibility requirements as described in this **Certificate** and on the Schedule of Benefits because of the **Member's** age or the death or divorce of **Subscriber**; or
- d. continuation coverage ceased under the COBRA Continuation Coverage section of this **Certificate**.

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

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

INQUIRY, COMPLAINT, GRIEVANCE AND APPEAL PROCEDURE

The following procedures govern inquiries, complaints, grievances and appeals made or submitted by **Members**.

A. Definitions

- 1. An "inquiry or complaint" is an oral or written contact from a **Member** which expresses a dissatisfaction regarding:
 - i. A service performed by the **HMO** or a **Participating Provider**;
 - ii.A request for an administrative service; or
 - iii. A request for information, or an opinion which include, but are not limited to issues concerning the scope of coverage, denials, cancellations, terminations or renewals, or the quality of care provided.
- 2. An "adverse decision" means a determination made by the **HMO** that:
 - i. an admission, availability of care, continued stay, or other health care service is or is not a covered benefit; and
 - ii. if it is a covered benefit, that it has been reviewed and does not meet the **HMO's** requirements for **Medical Necessity**, appropriateness, health care setting, level of care or effectiveness; and
 - iii. the requested service is therefore denied, reduced, limited, delayed or terminated.
- 3. An "appeal" means an oral or written request for reconsideration of a grievance.
- 4. A "final adverse decision" means a utilization review determination made by a physician advisor or peer of the treating health care provider in a reconsideration of an adverse decision.

5. A “grievance” means an oral or written request, filed by a **Member** or health care provider on behalf of a **Member** with the **HMO** through the **HMO**’s internal grievance process, for reconsideration of a decision by the **HMO** that involved a benefit determination, provider service, or quality of care issue.
6. A peer of the treating health care provider” means a physician or other health care professional who holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

B. Reconsideration of an HMO Decision – Level I

Informal Internal Process

1. **Members** with inquiries or complaints should contact the **HMO**, either verbally or in writing, at the **HMO**’s address and telephone number listed on the front of this amendment. Inquiries and complaints will be logged, triaged and routed to the appropriate **HMO** Department for resolution. If a **Member** is not satisfied with the resolution of their inquiry or complaint they may file a formal grievance. The grievance should contain sufficient information for the **HMO** to investigate and render a decision.
2. **Members** who are dissatisfied with an adverse decision may discuss and review the decision with the Medical Director, or other designee who rendered the decision. **Members** who wish to request a reconsideration of an adverse decision should file a formal grievance with the **HMO** at the following address and telephone number:

Senior Medical Director
Aetna Health Inc.
1301 McCormick Drive
Largo, Maryland 20774
1-888-287-4206

Formal Internal Process

Grievances will be routed directly to the **HMO**’s Regional Grievance Unit. The Regional Grievance Unit will send a written notice to the **Member** within five (5) working days of this initial contact. The notice will include the following:

- An acknowledgement that the grievance was received;
- The name, address, and telephone number of the Regional Grievance Unit;
- Instructions on how to submit written materials;
- The details of the internal appeal process and procedures; and
- If necessary for the review, a release form for the **Member**’s signature for the purpose of obtaining medical records or other information that may require their authorization for release.

Grievances will be handled as follows:

The Regional Grievance Unit will review, render a decision, and send a written notice to the **Member** or the health care provider, if filed on behalf of the **Member**, within fourteen (14) working days of receipt of the grievance. This notice will include:

- The decision, in clear terms, with the contractual (benefits) or clinical (medical appropriateness) rationale;
- The alternate length of treatment or alternate treatment settings, if any, that the **HMO** deems appropriate;
- A list of individuals participating in the review of the grievance, including their titles and an indication that credentialing information is available on request;
- A statement of the reviewer’s understanding of the pertinent facts of the grievance;
- A reference to the evidence or documentation used as the basis for the decision; and, in cases involving a denial of services, instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used; and
- A description of the next level of appeal (in at least 12 point typeface).

C. Appeal Hearing – Level II

1. The **Member** has thirty (30) days from the notification of the Level I decision to request a Level II appeal hearing.
2. Within ten (10) days of receipt of a written request for a Level II appeal hearing, the **HMO** will provide the **Member** filing the request with an acknowledgement letter.
3. The Regional Grievance Unit will review all of the information submitted and gather any additional information necessary to prepare and render a decision about the grievance. If there is insufficient information available to make a decision the Regional Grievance Unit will, within ten (10) working days of receipt of the grievance, notify the **Member** or health care provider on behalf of the **Member**, of the need for additional information. The Regional Grievance Unit also will offer to assist the **Member** or health care provider obtain the information.
4. The Regional Grievance Unit will set up the hearing and send written notification to the **Member** with the date, time and location of the hearing and a description of the Level II hearing process and the **Member’s** rights.
5. A review body at the local market (hereinafter the “Appeal Hearing Panel”) will be formed to handle the appeal hearing. The reviewers must not have participated in any prior review determinations. The composition of the review body must be peers of the treating health care provider (physician to physician; chiropractor to chiropractor) and must be board certified or board eligible in a discipline pertinent to the issue under review, if the appeal involves a medical necessity issue.
6. The **HMO** will hold appeal hearings as needed, but no more than thirty (30) days after receiving a request.
7. In the event a **Member** is unable to attend the hearing on the scheduled hearing day, the **Member** may request that the hearing be rescheduled to the next hearing day or heard in the **Member's** absence.
8. The **Member** will have the right to attend the appeal hearing, question the representative of **HMO** designated to appear at the hearing and any other witnesses, and present their case. The **Member** also will have the right to be assisted or represented by a person of the **Member's** choice, and to submit written material in support of their appeal. The **Member** may bring a physician or other expert(s) to testify on the **Member's** behalf. The **HMO** will also have the right to present

witnesses. Counsel for the **Member** may present the **Member's** case and question witnesses; if the **Member** is so represented. Similarly, the **HMO** also may choose to be represented by counsel. The Appeal Hearing Panel will have the right to question the **HMO** representative, the **Member** and any other witnesses.

9. The appeal hearing will be informal. The Appeal Hearing Panel will not apply formal rules of evidence in reviewing documentation or accepting testimony at the hearing. The Chair of the Appeal Hearing Panel will have the right to exclude redundant testimony or excessive argument by any party or witness.
10. A written record of the appeal hearing will be made by stenographic transcription. All testimony will be under oath.
11. Before the record is closed, the Chair of the Appeal Hearing Panel will ask both the **Member** and the **HMO** representative (or their counsel) whether there is any additional evidence or argument which the party wishes to present to the Appeal Hearing Panel. Once all evidence and arguments have been received, the record of the appeal hearing will be closed. The deliberations of the Appeal Hearing Panel will be confidential and will not be transcribed.
12. The Appeal Hearing Panel will render a written decision within five (5) working days of the conclusion of the appeal hearing. A fifteen (15) working day extension to resolve the appeal may be granted with the **Member's** written permission.

The written decision will contain:

- The decision, in clear terms, with the contractual (benefits) or clinical (medical appropriateness) rationale;
 - A list of individuals participating in the review of the appeal, including their titles and credentialing information;
 - A statement of the Appeal Hearing Panel's understanding of the pertinent facts of the appeal;
 - A reference to the evidence or documentation used as the basis for the decision, and in the cases involving a denial of services, instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used; and
 - Additional appeal rights (in at least 12-point typeface) including relevant external review rights.
13. If the deadline for completing the appeal is not met by the **HMO**, the **Member** or the health care provider on behalf of the **Member** will be relieved of the duty to exhaust the **HMO's** internal review process and may file a request for an external review, as described below.

D. **External Review**

Once the internal appeal process is exhausted (except as otherwise noted in this procedure) the **Member** may file a request for an external review with the Director of the Department of Health for the District of Columbia at the following address:

Grievance Coordinator
Department of Health
Office of the General Counsel

825 North Capitol Street, N.E.
Room 4119
Washington, DC 20002
(202) 442-5979

A request for an external review must be received by the Department of Health within thirty (30) working days after the date of receipt of the appeal hearing decision.

Instructions on how to request an external review are included with the Appeal Hearing Panel's response to the second level appeal.

E. Expedited Review of Adverse Decisions

1. The **Member** or health care provider on behalf of the **Member**, may request an expedited review at either Level I or Level II when an adverse decision is rendered for health care services that are proposed but have not been delivered, and the services are necessary to treat a condition or illness that would reasonably appear to seriously jeopardize the life or health of the **Member** or the **Member's** ability to regain maximum function, without immediate medical attention. The **Member** and health care provider will be notified immediately if the **HMO** does not have sufficient information to complete the expedited review and the **HMO** will assist the **Member** or health care provider in gathering the necessary information without further delay.
2. Expedited reviews will be performed by a physician advisor, a peer of the treating health care provider, or a panel of other appropriate health care providers, at least one of which is a physician advisor.
3. Expedited reviews will be completed within twenty-four (24) hours of the time the **Member** or health care provider initiates the request.
4. Within one (1) day after a decision has been orally communicated to the **Member** or health care provider, a written notice will be sent to the **Member** or health care provider. The notice will include:
 - The decision, in clear terms, with the contractual (benefits) or clinical (medical appropriateness) rationale;
 - A list of individuals participating in the review, including titles and credentialing information;
 - A statement of the reviewer's understanding of the pertinent facts of the review;
 - A reference to the evidence or documentation used as the basis for the decision, and in cases involving a denial of services, instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used; and
 - If the denial is upheld, a statement advising the **Member** or health care provider of their right to file a grievance and a description of how to file a grievance.
5. If the expedited review is a concurrent review determination, the service should be continued without liability to the **Member** until the **Member** is notified of the decision, unless it is related to an initial unauthorized admission.
6. The **HMO** is not required to provide an expedited review for retrospective non-certifications.

A Member may file a complaint with the Director of the Department of Health if a decision is not received within twenty-four (24) hours of the filing of the request for an expedited review.

F. **Record Retention.**

The **HMO** will retain the records of all grievances and appeals for a period of at least seven (7) years.

G. **Fees and Costs.**

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

H. **Dispute Resolution**

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

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

COORDINATION OF BENEFITS

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

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

- A. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- B. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.
- C. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

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

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

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

1. covers the person as other than a dependent; and
2. is secondary to Medicare.

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

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

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

1. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (E) above will apply.
2. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.
3. If there is not such a court decree:

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

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

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

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

1. laid-off or retired employee; or
2. the dependent of such person;

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

1. an employee who is not laid-off or retired; or
2. a dependent of such person.

If the other plan does not have a provision:

1. regarding laid-off or retired employees; and
2. as a result, each plan determines its benefits after the other,

then the above paragraph will not apply.

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

If the other plan does not have a provision:

1. regarding right of continuation pursuant to federal or state law; and
2. as a result, each plan determines its benefits after the other,

then the above paragraph will not apply.

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

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

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

1. Group insurance.
2. Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
3. No-fault and traditional "fault" auto insurance including medical payments coverage provided on other than a group basis to the extent allowed by law.

Payment of Benefits.

Under the **Coordination of Benefits** provision of this **Certificate**, the amount normally reimbursed for **Covered Benefits** under this **Certificate** is reduced to take into account payments made by other plans. The general rule is that the benefits otherwise payable under this **Certificate** for all **Covered Benefits** will be reduced by all other plan benefits payable for those expenses. When the **Coordination of Benefits** rules of this **Certificate** and another plan both agree that this **Certificate** determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved. Such reduced amount will be charged against any applicable benefit limit of this coverage.

Facility of Payment.

A payment made by another plan may include an amount which should have been paid under this **Certificate**. If it does, **HMO** may pay that amount to the plan that made that payment. That amount will then be treated as though it

were a benefit paid by **HMO**. **HMO** will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Recovery of Overpayments.

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

Medicare And Other Federal Or State Government Programs.

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

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

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

1. Are covered under a program;
2. Have refused to be covered under a program for which they are eligible;
3. Have terminated coverage under a program; or
4. Have failed to make proper request for coverage under a program.

Active Employees and Their Dependents Who Are Eligible For Medicare.

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

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

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

Provision for Coordination with Medicare

HMO reserves the right to figure the total amount of "regular benefits" for any medical benefits under this **Certificate**. (This will be the amount that would be payable if there were no Medicare benefits.) If this is more than the amount Medicare provides for the expenses involved, **HMO** will pay the difference. Otherwise, **HMO** will pay no benefits. This will be done for each claim. Charges for services used to satisfy a **Member's** Medicare Part B deductible will be applied under this **Certificate** in the order received by **HMO**. Two or more charges for services received at the same time will be applied starting with the largest first. Any rules for **Coordination of Benefits**, as

outlined in this **Certificate**, will be applied after **HMO's** benefits have been calculated under the rules in this section. **Covered Benefits** will be reduced by any Medicare benefits available for those **Covered Benefits**.

SUBROGATION AND RIGHT OF RECOVERY

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

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

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

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

- A. Notify **HMO** promptly and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to injuries or illness sustained by the **Member** that may be the legal responsibility of another party;
- B. Cooperate with **HMO** and do whatever is necessary to secure **HMO's** rights of subrogation and/or reimbursement under this **Certificate**;
- C. Give **HMO** a first-priority lien on any recovery, settlement or judgment or other source of compensation which may be had from any party to the extent of the full cost of all benefits associated with injuries or illness provided by **HMO** for which another party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement);
- D. Pay, as the first priority, from any recovery, settlement or judgment or other source of compensation, any and all amounts due **HMO** as reimbursement for the full cost of all benefits associated with injuries or illness provided by **HMO** for which another party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by **HMO** in writing; and
- E. Do nothing to prejudice **HMO's** rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by **HMO**.

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

RESPONSIBILITY OF MEMBERS

- A. **Members** or applicants shall complete and submit to **HMO** such application or other forms or statements as **HMO** may reasonably request. **Members** represent that all information contained in such applications, forms and statements submitted to **HMO** incident to enrollment under this **Certificate** or the administration herein shall be true, correct, and complete to the best of the **Member's** knowledge and belief.
- B. The **Member** shall notify **HMO** immediately of any change of address for the **Member** or any of the **Subscriber's Covered Dependents**, unless a different notification process is agreed to between **HMO** and **Contract Holder**.
- C. The **Member** understands that **HMO** is acting in reliance upon all information provided to it by the **Member** at time of enrollment and afterwards and represents that information so provided is true and accurate.
- D. By electing coverage pursuant to this **Certificate**, or accepting benefits hereunder, all **Members** who are legally capable of contracting, and the legal representatives of all **Members** who are incapable of contracting, at time of enrollment and afterwards, represent that all information so provided is true and accurate and agree to all terms, conditions and provisions in this **Certificate**.
- E. **Members** are subject to and shall abide by the rules and regulations of each **Provider** from which benefits are provided.

GENERAL PROVISIONS

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

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

- B. **Reports and Records.** **HMO** is entitled to receive from any **Provider** of services to **Members**, information reasonably necessary to administer this **Certificate** subject to all applicable confidentiality requirements as defined in the General Provisions section of this **Certificate**. By accepting coverage under this **Certificate**, the **Subscriber**, for himself or herself, and for all **Covered Dependents** covered hereunder, authorizes each and every **Provider** who renders services to a **Member** hereunder to:
 - 1. disclose all facts pertaining to the care, treatment and physical condition of the **Member** to **HMO**, or a medical, dental, or mental health professional that **HMO** may engage to assist it in reviewing a treatment or claim;

2. render reports pertaining to the care, treatment and physical condition of the **Member** to **HMO**, or a medical, dental, or mental health professional that **HMO** may engage to assist it in reviewing a treatment or claim; and
 3. permit copying of the **Member's** records by **HMO**.
- C. **Refusal of Treatment.** A **Member** may, for personal reasons, refuse to accept procedures, medicines, or courses of treatment recommended by a **Participating Provider**. If the **Participating Provider** (after a second **Participating Provider's** opinion, if requested by **Member**) believes that no professionally acceptable alternative exists, and if after being so advised, **Member** still refuses to follow the recommended treatment or procedure, neither the **Participating Provider**, nor **HMO**, will have further responsibility to provide any of the benefits available under this **Certificate** for treatment of such condition or its consequences or related conditions. **HMO** will provide written notice to **Member** of a decision not to provide further benefits for a particular condition. This decision is subject to the Grievance Procedure in this **Certificate**. Coverage for treatment of the condition involved will be resumed in the event **Member** agrees to follow the recommended treatment or procedure.
- D. **Assignment of Benefits.** All rights of the **Member** to receive benefits hereunder are personal to the **Member** and may not be assigned.
- E. **Legal Action.** No action at law or in equity may be maintained against **HMO** for any expense or bill unless and until the appeal process has been exhausted, and in no event prior to the expiration of 60 days after written submission of claim has been furnished in accordance with requirements set forth in the **Group Agreement**. No action shall be brought after the expiration of 3 years after the time written submission of claim is required to be furnished.
- F. **Independent Contractor Relationship.**
1. **Participating Providers**, non-participating **Providers**, institutions, facilities or agencies are neither agents nor employees of **HMO**. Neither **HMO** nor any **Member** of **HMO** is an agent or employee of any **Participating Provider**, non-participating **Provider**, institution, facility or agency.
 2. Neither the **Contract Holder** nor a **Member** is the agent or representative of **HMO**, its agents or employees, or an agent or representative of any **Participating Provider** or other person or organization with which **HMO** has made or hereafter shall make arrangements for services under this **Certificate**.
 3. **Participating Physicians** maintain the physician-patient relationship with **Members** and are solely responsible to **Member** for all **Medical Services** which are rendered by **Participating Physicians**.
 4. **HMO** cannot guarantee the continued participation of any **Provider** or facility with **HMO**. In the event a **PCP** terminates its contract or is terminated by **HMO**, **HMO** shall provide notification to **Members** in the following manner:
 - a. within 30 days of the termination of a **PCP** contract to each affected **Subscriber**, if the **Subscriber** or any **Dependent** of the **Subscriber** is currently enrolled in the **PCP's** office; and
 - b. services rendered by a **PCP** or **Hospital** to an enrollee between the date of termination of the Provider Agreement and 5 business days after notification of the contract termination is mailed to the **Member** at the **Member's** last known address shall continue to be **Covered Benefits**.
 5. **Restriction on Choice of Providers:** Unless otherwise approved by **HMO**, **Members** must utilize **Participating Providers** and facilities who have contracted with **HMO** to provide services.

- G. **Inability to Provide Service.** If due to circumstances not within the reasonable control of **HMO**, including but not limited to, major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of the Participating Provider Network, the provision of medical or **Hospital** benefits or other services provided under this **Certificate** is delayed or rendered impractical, **HMO** shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid **Premiums** held by **HMO** on the date such event occurs. **HMO** is required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.
- H. **Confidentiality.** Information contained in the medical records of **Members** and information received from any **Provider** incident to the provider-patient relationship shall be kept confidential in accordance with applicable law. Information may be used or disclosed by **HMO** when necessary for a **Member's** care or treatment, the operation of **HMO** and administration of this **Certificate**, or other activities, as permitted by applicable law. **Members** can obtain a copy of **HMO's** Notice of Information Practices by calling the Member Services toll-free telephone number listed on the **Member's** identification card.
- I. **Limitation on Services.** Except in cases of **Emergency Services** or **Urgent Care**, or as otherwise provided under this **Certificate**, services are available only from **Participating Providers** and **HMO** shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a **Member** from any **Physician, Hospital, Skilled Nursing Facility**, home health care agency, or other person, entity, institution or organization unless prior arrangements are made by **HMO**.
- J. **Incontestability.** In the absence of fraud, all statements made by a **Member** shall be considered representations and not warranties, and no statement shall be the basis for voiding coverage or denying a claim after the **Group Agreement** has been in force for 2 years from its effective date, unless the statement was material to the risk and was contained in a written application.
- K. This **Certificate** applies to coverage only, and does not restrict a **Member's** ability to receive health care benefits that are not, or might not be, **Covered Benefits**.
- L. **Contract Holder** hereby makes **HMO** coverage available to persons who are eligible under the Eligibility and Enrollment section of this **Certificate**. However, this **Certificate** shall be subject to amendment, modification or termination in accordance with any provision hereof, by operation of law, by filing with and approval by the state Department of Insurance. This can also be done by mutual written agreement between **HMO** and **Contract Holder** without the consent of **Members**.
- M. **HMO** may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this **Certificate**.
- N. No agent or other person, except an authorized representative of **HMO**, has authority to waive any condition or restriction of this **Certificate**, to extend the time for making a payment, or to bind **HMO** by making any promise or representation or by giving or receiving any information. No change in this **Certificate** shall be valid unless evidenced by an endorsement to it signed by an authorized representative of **HMO**.
- O. This **Certificate**, including the Schedule of Benefits, any riders, and any amendments, endorsements, inserts, or attachments, constitutes the entire **Certificate** between the parties hereto pertaining to the subject matter hereof and supersedes all prior and contemporaneous arrangements, understandings, negotiations and discussions of the parties with respect to the subject matter hereof, whether written or oral. There are no warranties, representations, or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth in this **Certificate**. No supplement, modification or waiver of this **Certificate** shall be binding unless executed in writing by authorized representatives of the parties.
- P. This **Certificate** has been entered into and shall be construed according to applicable state and federal law.

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

DEFINITIONS

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

- **Behavioral Health Provider.** A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.
- **Certificate.** This **Certificate**, including the Schedule of Benefits, any riders, and any amendments, endorsements, inserts, or attachments, which outlines coverage for a **Subscriber** and **Covered Dependents** according to the **Group Agreement**.
- **Contract Holder.** An employer or organization who agrees to remit the **Premiums** for coverage under the **Group Agreement** payable to **HMO**. The **Contract Holder** shall act only as an agent of **HMO Members** in the **Contract Holder's** group, and shall not be the agent of **HMO** for any purpose.
- **Contract Year.** A period of 1 year commencing on the **Contract Holder's Effective Date of Coverage** and ending at 12:00 midnight on the last day of the 1 year period.
- **Coordination of Benefits.** A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by 2 or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing the authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first. Refer to the Coordination of Benefits section of this **Certificate** for a description of the **Coordination of Benefits** provision.
- **Copayment.** The specified dollar amount or percentage required to be paid by or on behalf of a **Member** in connection with benefits, if any, as set forth in the Schedule of Benefits. **Copayments** may be changed by **HMO** upon 30 days written notice to the **Contract Holder**.
- **Copayment Maximum.** The maximum annual out-of-pocket amount for payment of **Copayments**, if any, to be paid by a **Subscriber** and any **Covered Dependents**.
- **Cosmetic Surgery.** Any non-medically necessary surgery or procedure whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem, but which does not restore bodily function, correct a diseased state, physical appearance, or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. **Cosmetic Surgery** includes, but is not limited to, ear piercing, rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of **Cosmetic Surgery**.
- **Covered Dependent.** Any person in a **Subscriber's** family who meets all the eligibility requirements of the Eligibility and Enrollment section of this **Certificate** and the Dependent Eligibility section of the Schedule of Benefits, has enrolled in **HMO**, and is subject to **Premium** requirements set forth in the Premiums section of the **Group Agreement**.

- **Covered Benefits.** Those **Medically Necessary Services** and supplies set forth in this **Certificate**, which are covered subject to all of the terms and conditions of the **Group Agreement** and **Certificate**.
- **Creditable Coverage.** Coverage of the **Member** under a group health plan (including a governmental or church plan), a health insurance coverage (either group or individual insurance), Medicare, Medicaid, a military-sponsored health care (CHAMPUS), a program of the Indian Health Service, a State health benefits risk pool, the Federal Employees Health Benefits Program (FEHBP), a public health plan, and any health benefit plan under section 5(e) of the Peace Corps Act. **Creditable Coverage** does not include coverage only for accident; Workers' Compensation or similar insurance; automobile medical payment insurance; coverage for on-site medical clinics; or limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits that is provided in a separate policy.
- **Custodial Care.** Any type of care provided in accordance with Medicare guidelines, including room and board, that a) does not require the skills of technical or professional personnel; b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-hospital **Skilled Nursing Facility** care; or c) is a level such that the **Member** has reached the maximum level of physical or mental function and such person is not likely to make further significant improvement. **Custodial Care** includes, but is not limited to, any type of care where the primary purpose of the type of care provided is to attend to the **Member's** daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of this include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication which can be self-administered by the **Member**, general maintenance care of colostomy or ileostomy, routine services to maintain other service which, in the sole determination of **HMO**, based on medically accepted standards, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical or paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest cures, convalescent care.
- **Detoxification.** The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed **Physician**, while keeping the physiological risk to the patient at a minimum.
- **Durable Medical Equipment (DME).** Equipment, as determined by **HMO**, which is a) made for and mainly used in the treatment of a disease or injury; b) made to withstand prolonged use; c) suited for use while not confined as an inpatient in the **Hospital**; d) not normally of use to persons who do not have a disease or injury; e) not for use in altering air quality or temperature; and f) not for exercise or training.
- **Effective Date of Coverage.** The commencement date of coverage under this **Certificate** as shown on the records of **HMO**.
- **Emergency Service.** Professional health services that are provided to treat a **Medical Emergency**.
- **Experimental or Investigational Procedures.** Services or supplies that are, as determined by **HMO**, experimental. A drug, device, procedure or treatment will be determined to be experimental if:
 1. there is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
 2. required FDA approval has not been granted for marketing; or
 3. a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or

4. the written protocol or protocol(s) used by the treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or
 5. it is not of proven benefit for the specific diagnosis or treatment of a **Member's** particular condition; or
 6. it is not generally recognized by the **Medical Community** as effective or appropriate for the specific diagnosis or treatment of a **Member's** particular condition; or
 7. it is provided or performed in special settings for research purposes.
- **Group Agreement.** The **Group Agreement** between **HMO** and the **Contract Holder**, including the Group Application, this **Certificate**, including the Schedule of Benefits, any riders, and any amendments, endorsements, inserts, or attachments, as subsequently amended by operation of law and as filed with and approved by the applicable public authority.
 - **Health Professional(s).** A **Physician** or other professional who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides **Medical Services** which are within the scope of the individual's license or certificate.
 - **Health Maintenance Organization (HMO).** Aetna Health Inc., a Maryland corporation licensed by the District of Columbia Department of Insurance and Securities Regulation as a **Health Maintenance Organization** .
 - **Homebound Member.** A **Member** who is confined to the home due to an illness or injury which makes leaving the home medically contraindicated or which restricts the **Member's** ability to leave the **Member's** place of residence except with the aid of supportive devices, the use of special transportation, or the assistance of another person.
 - **Home Health Services.** Those items and services provided by **Participating Providers** as an alternative to hospitalization, and coordinated and pre-authorized by **HMO**.
 - **Hospice Care.** A program of care that is provided by a **Hospital, Skilled Nursing Facility**, hospice, or a duly licensed Hospice Care agency, and is approved by **HMO**, and is focused on a palliative rather than curative treatment for **Members** who have a medical condition and a prognosis of less than 6 months to live.
 - **Hospital(s).** An institution rendering inpatient and outpatient services, accredited as a **Hospital** by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by **HMO** as meeting reasonable standards. A **Hospital** may be a general, acute care, rehabilitation or specialty institution.
 - **Infertile or Infertility.** The condition of a presumably healthy **Member** who is unable to conceive or produce conception after a period of 1 year of frequent, unprotected heterosexual sexual intercourse. This does not include conditions for male **Members** when the cause is a vasectomy or orchiectomy or for female **Members** when the cause is a tubal ligation or hysterectomy.
 - **Interested Parties** means **Contract Holder** and **Members**, including any and all affiliates, agents, assigns, employees, heirs, personal representatives or subcontractors of an **Interested Party**.
 - **Medical Community.** A majority of **Physicians** who are Board Certified in the appropriate specialty.
 - **Medical Emergency.** The existence of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average

knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

- **Medical Services.** The professional services of **Health Professionals**, including medical, surgical, diagnostic, therapeutic, preventive care and birthing facility services.
- **Medically Necessary, Medically Necessary Services, or Medical Necessity.** Services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards as described in the Covered Benefits section of this **Certificate**. **Medical Necessity**, when used in relation to services, shall have the same meaning as **Medically Necessary Services**. This definition applies only to the determination by **HMO** of whether health care services are **Covered Benefits** under this **Certificate**.
- **Member(s).** A **Subscriber** or **Covered Dependent** as defined in this **Certificate**.
- **Mental or Behavioral Condition.** A condition which manifests signs and/or symptoms which are primarily mental or behavioral, for which the primary treatment is psychotherapy, psychotherapeutic methods or procedures, and/or the administration of psychotropic medication, regardless of any underlying physical or medical cause. Mental or behavioral disorders and conditions include, but are not limited to, psychosis, affective disorders, anxiety disorders, personality disorders, obsessive-compulsive disorders, attention disorders with or without hyperactivity, and other psychological, emotional, nervous, behavioral, or stress-related abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems, whether or not caused by or in any way resulting from chemical imbalance, physical trauma, or a physical or medical condition.
- **Non-Hospital Facility.** A facility, licensed by the appropriate regulatory authority, for the care or treatment of alcohol or drug dependent persons, except for transitional living facilities.
- **Open Enrollment Period.** A period each calendar year, when eligible enrollees of the **Contract Holder** may enroll in **HMO** without a waiting period or exclusion or limitation based on health status or, if already enrolled in **HMO**, may transfer to an alternative health plan offered by the **Contract Holder**.
- **Partial Hospitalization.** The provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a **Hospital** or **Non-Hospital Facility** which is licensed as an alcohol or drug abuse or mental illness treatment program by the appropriate regulatory authority, and which is designed for a patient or client who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care.
- **Participating.** A description of a **Provider** that has entered into a contractual agreement with **HMO** for the provision of services to **Members**.
- **Participating Infertility Specialist.** A **Specialist** who has entered into a contractual agreement with **HMO** for the provision of **Infertility** services to **Members**.
- **Physician(s).** A duly licensed member of a medical profession, who has an M.D. or D.O. degree, who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides **Medical Services** which are within the scope of the individual's license or certificate.
- **Premium(s).** The amount the **Contract Holder** or **Member** is required to pay to **HMO** to continue coverage.
- **Primary Care Physician (PCP).** A **Participating Physician** who supervises, coordinates and provides initial care and basic **Medical Services** as a general or family care practitioner, or in some cases, as an

internist or a pediatrician to **Members**, initiates their **Referral** for **Specialist** care, and maintains continuity of patient care.

- **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.