AETNA HEALTH INC.
(NORTH CAROLINA)

GROUP AGREEMENT COVER SHEET

READ YOUR POLICY CAREFULLY.
THIS CONTRACT IS A LEGAL DOCUMENT BETWEEN THE CONTRACT HOLDER AETNA HEALTH INC.

Important Cancellation Information - Please read entire Contract Holder Termination Section. Contract Holder shall be given 45 days notice prior to the effective date of any rate increase.

Contract Holder:	Government of the District of Columbia
Contract Holder Number:	172614 047
HMO Referred Benefit Level:	CHARTER OPEN ACCESS PLAN Benefits Package
Effective Date:	12:01 a.m. on January 1, 2013
Term of **Group Agreement:**	The **Initial Term** shall be: From January 1, 2013 through December 31, 2013 Thereafter, **Subsequent Terms** shall be: From January 1st through December 31st
Premium Due Dates:	The **Group Agreement Effective Date** and the 1st day of each succeeding calendar month.
Governing Law:	Federal law and the laws of North Carolina

Notice Address for **HMO**:

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

The signature below is evidence of Aetna Health Inc.'s acceptance of the **Contract Holder's** Group Application on the terms hereof and constitutes execution of the **Group Agreement(s)** attached hereto on behalf of Aetna Health Inc.

AETNA HEALTH INC.

By: Gregory S. Martino
Gregory S. Martino
Vice President

Contract Holder Name: Government of the District of Columbia
Contract Holder Number: 172614
Contract Holder Locations: 047
Contract Holder Group Agreement Effective Date: January 1, 2013

NOTICE TO FIDUCIARIES OF OBLIGATIONS

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSONS, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH CARE PLAN PREMIUMS, SHALL: (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH CARE PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLINGLY FAILING TO PAY SUCH THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS PRIOR TO BEFORE THE TERMINATION OF SUCH THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES CHAPTER 58 AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) HEALTH INSURANCE PORTABILITY AND ACCOUNTABIITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

TABLE OF CONTENTS

AETNA HEALTH INC.
(NORTH CAROLINA)

GROUP AGREEMENT

This **Group Agreement** is entered into by and between Aetna Health Inc. (**"HMO"**) and the **Contract Holder** specified in the attached Cover Sheet. This **Group Agreement** shall be effective on the **Effective Date** specified in the Cover Sheet, and shall continue in force until terminated as provided herein.

In consideration of the mutual promises hereunder and the payment of **Premiums** and fees when due, **We** will provide coverage for benefits in accordance with the terms, conditions, limitations and exclusions set forth in this **Group Agreement**.

Upon acceptance by **Us** of **Contract Holder's** Group Application, and upon receipt of the required initial **Premium**, this **Group Agreement** shall be considered to be agreed to by **Contract Holder** and **Us**, and is fully enforceable in all respects against **Contract Holder** and **Us**.

SECTION 1. DEFINITIONS

1.1 The terms **"Contract Holder"**, **"Effective Date"**, **"Initial Term"**, **"Premium Due Date"** and **"Subsequent Terms"** will have the meaning set forth in the attached Cover Sheet. If any of such terms are undefined in the Cover Sheet, such undefined terms shall have the following meaning:

- **"Effective Date"** would mean the date health coverage commences for the **Contract Holder**.
- **"Initial Term"** would be the 12 month period following the **Effective Date** as indicated on the Cover Sheet.
- **"Premium Due Date(s)"** would be the **Effective Date** and each monthly anniversary of the **Effective Date**.
- **"Subsequent Term(s)"** would mean the 12 month period following the **Initial Term** as indicated on the Cover Sheet.

1.2 The terms **"HMO"**, **"Us"**, **"We"** or **"Our"** mean Aetna Health Inc.

1.3 **"Certificate"** means the Certificate of Coverage issued pursuant to this **Group Agreement**.

1.4 **"Grace Period"** is defined in Section 3.3.

1.5 **"Group Agreement"** means the **Contract Holder's** Group Application, this document, the attached Cover Sheet; the **Certificate** and Schedule of Benefits issued hereunder; the initial rate sheet and any subsequent indication of rates issued by **Us** in connection with this **Group Agreement**; and any riders, amendments, endorsements, inserts or attachments issued pursuant hereto, all of which are incorporated into and made a part of this **Group Agreement**.

1.6 **"Party, Parties"** means **HMO** and **Contract Holder**.

1.7 **"Premium(s)"** is defined in Section 3.1.

1.8 **"Renewal Date"** means the first day following the end of the **Initial Term** or any **Subsequent Term**.

1.9 **"Term"** means the **Initial Term** or any **Subsequent Term**.

1.10 Capitalized and bolded terms not defined in this **Group Agreement** shall have the meaning set forth in the **Certificate**. In the event of a conflict between the terms of this **Group Agreement** and the terms of the **Certificate**, the terms of this **Group Agreement** shall prevail.

SECTION 2. COVERAGE

2.1 **Covered Benefits.** **We** will provide coverage for **Covered Benefits** to **Members** subject to the terms and conditions of this **Group Agreement**. Coverage will be provided in accordance with the reasonable exercise of **Our** business judgment, consistent with applicable law. **Members** covered under this **Group Agreement** are subject to all of the conditions and provisions contained herein and in the incorporated documents.

2.2 **Policies and Procedures.** **We** have the right to adopt reasonable policies, procedures, rules, and interpretations of this **Group Agreement** and the **Certificate** in order to promote orderly and efficient administration.

SECTION 3. PREMIUMS AND FEES

3.1 **Premiums.** **Contract Holder** shall pay **Us** on or before each **Premium Due Date** a monthly advance premium (the **"Premium"**) determined in accordance with the **Premium** rates and the manner of calculating **Premiums** specified by **HMO**. **Premium** rates and the manner of calculating **Premiums** may be adjusted in accordance with Section 3.5 below. **Premiums** are subject to adjustment, if any, for partial month participation as specified in Section 3.4 below. Membership as of each **Premium Due Date** will be determined by **Us** in accordance with **Our Member** records. A check does not constitute payment until it is honored by a bank. **We** may return a check issued against insufficient funds without making a second deposit attempt. **We** may accept a partial payment of **Premium** without waiving our right to collect the entire amount due.

3.2 **Fees.** In addition to the **Premium**, **We** may charge the following fees:

- An installation fee may be charged upon initial installation of coverage or any significant change in installation (e.g., a significant change in the number of **Members** or a change in the method of reporting **Member** eligibility to **Us**). A fee may also be charged upon initial installation for any custom plan set-ups.

- A billing fee may be added to each monthly **Premium** bill. The billing fee may include a fee for the recovery of any surcharges for amounts paid through credit card, debit card or other similar means.

- A reinstatement fee as set forth in Section 6.4.

3.3 **Past Due Premiums and Fees.** If a **Premium** payment or any fees are not paid in full by **Contract Holder** on or before the **Premium Due Date**, a late payment charge of 1½% of the total amount due per month (or partial month) will be added to the amount due. If all **Premiums** and fees are not received before the end of a 31 day grace period (the **"Grace Period"**), this **Group Agreement** will be automatically terminated pursuant to Section 6.3 hereof.

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

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

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

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

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

3.5 **Changes in Premium.** **We** may also adjust the **Premium** rates and/or the manner of calculating **Premiums** effective as of any **Premium Due Date** at the commencement of any **Subsequent Term** upon 45 days' prior written notice to **Contract Holder**. No such adjustment will be made during the **Initial Term** of this Agreement except to reflect changes in applicable law or regulation or a judicial decision having a material impact on the cost of providing **Covered Benefits** to **Members**. Any rate change must first be approved by the Department of Insurance before use.

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

SECTION 4. ENROLLMENT

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

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

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

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

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

4.3 **Eligibility.** The number of eligible individuals and dependents and composition of the group, the identity and status of the **Contract Holder**, the eligibility requirements used to determine membership in the group, and the participation and contribution standards applicable to the group which exist at the **Effective Date** of this **Group Agreement** are material to the execution and continuation of this **Group Agreement** by **Us**. The **Contract Holder** shall not, during the term of this **Group Agreement**, modify the **Open Enrollment**

Period, the waiting period as described on the **Schedule of Benefits**, or any other eligibility requirements as described in the **Certificate** and on the **Schedule of Benefits**, for the purposes of enrolling **Contract Holder's** eligible individuals and dependents under this **Group Agreement**, unless **We** agree to the modification in writing.

SECTION 5. RESPONSIBILITIES OF THE CONTRACT HOLDER

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

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

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

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

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

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

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

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

SECTION 6. TERMINATION

6.1 **Termination by Contract Holder.** This **Group Agreement** may be terminated by **Contract Holder** as of any **Premium Due Date** by providing **Us** with 45 days' prior written notice. However, **We** may in **Our** discretion accept an oral indication by **Contract Holder** or it's agent or broker of intent to terminate.

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

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

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

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

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

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

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

- Upon 180 days' written notice to **Contract Holder** and Members if **We** cease to offer coverage in a market in which **Members** covered under this **Group Agreement** reside;

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

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

6.5 **Notice to Subscribers and Members.** Both **We** and the **Contract Holder** have the responsibility to notify the **Members** of the termination of the **Group Agreement** in compliance with all applicable laws. However, **We** reserve the right to notify **Members** of termination of the **Group Agreement** for any reason,

including non-payment of **Premium**. In accordance with the **Certificate**, the **Contract Holder** shall provide written notice to **Members** of their rights upon termination of coverage.

SECTION 7. PRIVACY OF INFORMATION

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

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

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

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

SECTION 8. INDEPENDENT CONTRACTOR RELATIONSHIPS

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

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

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

SECTION 9. MISCELLANEOUS

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

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

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

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

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

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

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

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

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

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

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

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

9.10 **Waiver.** **Our** failure to implement, or insist upon compliance with, any provision of this **Group Agreement** or the terms of the **Certificate** incorporated hereunder, at any given time or times, shall not constitute a waiver of **Our** right to implement or insist upon compliance with that provision at any other

time or times. This includes, but is not limited to, the payment of **Premiums** or benefits. This applies whether or not the circumstances are the same.

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

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

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

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

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

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

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

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

HEALTH CARE REFORM CONTRIBUTION CHANGE NOTICE

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

AETNA HEALTH INC.
NORTH CAROLINA

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. Provisions of this **Certificate** include the Schedule of Benefits, and any amendments, riders or endorsements. Amendments, riders or endorsements 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**.

This **Certificate** describes covered health care benefits. Coverage for services or supplies is provided only if it is furnished while an individual is a **Member**. This means that coverage is provided only for health care services furnished while this coverage is in force. Except as shown in the Continuation and Conversion section of this **Certificate**, coverage is not provided for any services received before coverage starts or after coverage ends.

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 North Carolina.

READ THIS ENTIRE CERTIFICATE CAREFULLY. THIS CERTIFICATE IS A LEGAL DOCUMENT BETWEEN THE CONTRACT HOLDER AND AETNA HEALTH INC.

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.

Important Cancellation Information -

Please read entire Termination of Coverage section

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

NO SERVICES ARE COVERED UNDER THIS CERTIFICATE IN THE ABSENCE OF PAYMENT OF CURRENT PREMIUMS SUBJECT TO THE 31 DAY 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.

NO PARTICIPATING PROVIDER OR OTHER PROVIDER, INSTITUTION, FACILITY OR AGENCY IS AN AGENT OR EMPLOYEE OF HMO.

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

TABLE OF CONTENTS

HMO PROCEDURE

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

At the time of enrollment, each **Member** should select a **Participating Primary Care Physician (PCP)** from **HMO's** Directory of Participating Providers to access **Covered Benefits** as described in this **Certificate**. The choice of a **PCP** is made solely by the **Member**. If the **Member** is a minor or otherwise incapable of selecting a **PCP**, the **Subscriber** should select a **PCP** on the **Member's** behalf. Until a **PCP** is selected, benefits will be limited to coverage for **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. Except in a **Medical Emergency** or for certain direct access **Specialist** benefits as described in this **Certificate**, only those services which are provided by or referred by a **Member's PCP** will be covered. **Covered Benefits** are described in the Covered Benefits section of this **Certificate**. It is a **Member's** responsibility to consult with the **PCP** in all matters regarding the **Member's** medical care.

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

C. **Availability of Providers.**

HMO cannot guarantee the availability or continued participation of a particular **Provider**. Either **HMO** or any **Participating Provider** may terminate the **Provider** contract or limit the number of **Members** that will be accepted as patients. If the **PCP** initially selected cannot accept additional patients, the **Member** will be notified and given an opportunity to make another **PCP** selection. The **Member** must then cooperate with **HMO** to select another **PCP**. Until a **PCP** is selected, benefits are limited to coverage for **Medical Emergency** care. **HMO** shall not penalize a **Member** for use of a non-participating **Provider** if services of a **Participating Provider** are not available to a **Member** without an unreasonable delay.

D. **Changing a PCP.**

A **Member** may change the **PCP** at any time by calling the Member Services 800 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.

F. **Authorization.**

Certain services and supplies under this **Certificate** may require authorization by **HMO** to determine if they are **Covered Benefits** under this **Certificate**. Those services and supplies requiring **HMO** authorization are indicated in 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, proposed adoptive children, a child under court order) who meets the eligibility requirements described on the Schedule of Benefits.

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

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 and Foster Child.

      A newborn or foster 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 the **Subscriber** does not presently have dependent coverage and/or an additional **Premium** is required to provide coverage for the newborn or foster child. If the **Subscriber** has dependent coverage and if no additional **Premium** is required for the dependent, coverage will be continued beyond 31 days. However the **Subscriber** is encouraged to notify **HMO** within 31 days to ensure that the dependent is presently enrolled and coverage is in place.

      The coverage for newly born, foster, 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 and Foster Children.

A legally adopted child, foster child by order of the court or a child for whom a **Subscriber** is a court appointed legal guardian, and who meets the definition of a **Covered Dependent**, will be treated as a dependent from the date of adoption or upon the date the child was placed for adoption with the **Subscriber**. "Placed for adoption" means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child. If the **Subscriber** presently has dependent coverage and if no additional **Premium** is required for the dependent, coverage will be continued beyond 31 days. However the **Subscriber** must notify **HMO** within 31 days to ensure that the dependent is properly enrolled and coverage is in place.

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

4. Special Rules Which Apply to Children.

a. Qualified Medical 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, and is issued on or after the date the **Subscriber's** coverage becomes effective. The child must meet the definition of a **Covered Dependent**, and the **Subscriber** must make a written request for coverage or the child/children under court order may be enrolled by the non-covered parent or the Department of Human Resources in connection with its administration of the Medical Assistance or Child Support Enforcement Program.

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

b. Handicapped Children.

Coverage is available for a child who is chiefly dependent upon the **Subscriber** for support and maintenance, and who is 19 years of age or older but incapable of self-support due to mental or physical incapacity. The incapacity must have commenced prior to the age the dependent 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**, but not more frequently than annually. 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**. 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 any eligible dependents may be enrolled during a special enrollment period. A special enrollment period occurs when:

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

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

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

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

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

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

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

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

The effective date of coverage will be the first day of the first calendar month following the date the completed request for enrollment is received.

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

C. **Effective Date of Coverage.**

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

1. Hospital Confinement on Effective Date of Coverage.

If a **Subscriber** is an inpatient in a **Hospital** on the **Effective Date of Coverage**, the **Subscriber** will be covered as of that date. Such services are not covered if the **Subscriber** 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 **Subscriber** 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**.

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

- provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury or disease.
- not for experimental, investigational or cosmetic purposes.
- necessary for and appropriate to the diagnosis, treatment, cure or relief of a health condition , illness, injury, disease or its symptoms.
- within generally accepted standards of medical care in the community.
- not solely for the convenience of the **Member**, the **Member's** family or the **Provider**.

For **Medically Necessary** services, nothing in the bullets above preclude an **HMO** from comparing the cost comparing the cost-effectiveness of alternative services or supplies when determining which the services or supplies will be covered.

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 800 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; and
   b. identify himself or herself as a **Member**; and
   c. follow the **PCP's** or covering **Physician's** instructions.

If the **Member's** injury or illness is 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**. Or the **Member** may also go directly to a **Participating** gynecologist without a **Referral** for routine GYN examinations and pap smears. See the Direct Access Specialist Benefits section of this **Certificate** for a description of these benefits.

   d. routine hearing screenings.

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

   f. routine vision screenings.

6. Injections, including allergy desensitization injections.

7. Casts and dressings.

8. Health Education Counseling and Information.

9. Diabetic Supplies and Equipment. The following equipment, supplies and education services for the treatment of diabetic conditions are covered when ordered or prescribed by a **Participating Physician** (or **Participating** nurse practitioner or clinical nurse specialist) and obtained through a **Participating Provider**: blood glucose monitors and blood glucose monitors for the legally blind, test strips for glucose monitors and visual reading and urine test strips, insulin, injection aids, cartridges for the legally blind, syringes, insulin pumps and appurtenances thereto, insulin infusion devices, and oral agents for controlling blood sugar.

   Coverage also includes diabetes self-management education to ensure that **Members** with diabetes are educated as to the proper self-management and treatment of their diabetic condition, including information on proper diet. Such coverage for self-management education and education relating to diet shall be limited to visits **Medically Necessary** upon the diagnosis of diabetes, where a **Participating Physician** (or **Participating** nurse practitioner or clinical nurse specialist) diagnoses a significant change in the patient's symptoms or conditions which necessitate changes in a **Member's** self-management, or where re-education or refresher education is necessary. Such education must be provided by a **Participating** dietitian registered by a nationally recognized professional association of dietitians or a health professional recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators.

B. **Diagnostic Services.**

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 prior authorization from **HMO** to a **Participating Provider**, prior to receiving this benefit.

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

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

3. prostate specific antigen tests, by a **Participating Provider** are provided for male **Members**.

C. **Specialist Physician Benefits.**

Covered Benefits include outpatient and inpatient services.

D. **Direct Access Specialist Benefits.**

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

- Routine Gynecological Examination(s). Routine gynecological visit(s) and pap smear(s). The maximum number of visits, if any, is listed on the Schedule of Benefits.
- Open Access to Gynecologists. Benefits are provided to female **Members** age 13 and older 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 **Infertility** benefits.
- Routine Eye Examinations, including refraction, as follows:

  1. if the **Member** is age 1 through 18 and wears eyeglasses or contact lenses, one exam every 12-month period.
  2. if the **Member** is age 19 and over and wears eyeglasses or contact lenses, one exam every 24-month period.
  3. if the **Member** is age 1 through 45 and does not wear eyeglasses or contact lenses, one exam every 36-month period.
  4. if the **Member** is age 46 and over and does not wear eyeglasses or contact lenses, one exam every 24-month period.

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

Outpatient and inpatient pre-natal and postpartum care and obstetrical services provided by **Participating Providers** are a **Covered Benefit**. To be covered for these benefits, the **Member** must choose a **Participating** obstetrician from **HMO's** list of **Participating Providers** and inform **HMO** by calling the Member Services 800 telephone number listed on the **Member's** identification card, prior to receiving services. The **Participating Provider** is responsible for obtaining prior authorization for all obstetrical care from **HMO** after the first prenatal visit. Preauthorization is not required for a statutory inpatient maternity stay.

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

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 preauthorization 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.

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

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

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

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

   If a **Member** requests a shorter **Hospital** stay, the **Member** will be covered for timely post delivery follow-up care that occurs not later than 72 hours immediately following discharge. This benefit is in addition to the home health maximum number of visits, if any, shown on the Schedule of Benefits. A **Copayment** will not apply for home health care visits.

In addition, coverage shall be provided for post mastectomy inpatient care. A determination to discharge the patient following a mastectomy shall be made by the **Participating Provider** in conjunction with the **Member**.

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

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 approved by **HMO's** Medical Director in advance of the surgery. The transplant must be performed at **Hospitals** specifically approved and designated by **HMO** to perform these procedures. Travel and lodging expenses are covered for the **Member** and for the parent or guardian when accompanying a minor for a transplant procedure outside the service area. A transplant is non-experimental and non-investigational hereunder when **HMO** has determined, in its sole discretion, that the **Medical Community** has generally accepted the procedure as appropriate treatment for the specific condition of the **Member**. Coverage for a transplant where a **Member** is the recipient includes coverage for the medical and surgical expenses of a live donor, to the extent these services are not covered by another plan or program.

H. **Outpatient Surgery Benefits.**

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

I. **Substance Abuse Benefits.**

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

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

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

J. **Mental Health Benefits.**

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

1. Outpatient benefits are covered for short-term, outpatient evaluative and crisis intervention or home health mental health services, and is 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, non-hospital residential facility, appropriately licensed by the Department of Health or its equivalent. Coverage, if applicable, is subject to the maximum number of days, if any, shown on the Schedule of Benefits.

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

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

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

1. A **Member** is covered for **Emergency Services** for treatment of a **Medical Emergency**, provided the service is a **Covered Benefit**, and **HMO's** medical review determines that the **Member's** symptoms were severe, occurred suddenly, and immediate medical attention was sought by **Member**. A **Medical Emergency** is a medical condition manifesting itself by acute symptoms of sufficient severity, including but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following: 1) placing the health of a **Member** or with respect to a pregnant women, the health of the female **Member** or her unborn child in serious jeopardy 2) serious impairment to bodily functions 3) serious dysfunction to any bodily organ or part.

   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 **Stabilized** and able 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. The **Member** will be covered for **Urgent Care** services obtained from a licensed **Physician** or facility outside of the **Service Area** if:

   a. the service is a **Covered Benefit**;

   b. a **Member** could not reasonably have anticipated the need for such care prior to leaving the **Service Area**; and

   c. a delay in receiving services and supplies until a **Member** could reasonably return and receive care from a **Participating Provider** would have caused serious deterioration of the **Member's** health.

3. A **Member** is covered for any follow-up care. Follow-up care is any care directly related to the need for emergency care which is provided to a **Member** after the **Medical Emergency** care 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.**

1. Inpatient and Outpatient Rehabilitation Benefits.

   The following benefits are covered by **Participating Providers** upon **Referral** issued by the **Member's PCP** and approved by **HMO** in advance of treatment.

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

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

2. Outpatient Rehabilitation Benefits.

The following benefits are covered by **Participating Providers** upon **Referral** issued by the **Member's PCP** and approved by **HMO** in advance of treatment. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.

a. 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**.

b. Physical therapy is covered for non-chronic conditions and acute illnesses and injuries.

c. Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute illnesses.

d. Speech therapy is covered for non-chronic conditions and acute illnesses and injuries. 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. Preauthorization 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. Coverage is subject to the maximum number of visits, if any, shown on the Schedule of Benefits.

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. Services are subject to the limitations listed in the Rehabilitation Benefits section of this **Certificate**.

N. **Hospice Benefits.**

Hospice Care services for a terminally ill **Member** are covered when preauthorized 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 above.

Coverage is not provided for bereavement counseling, funeral arrangements, pastoral counseling, 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 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** and authorized in advance 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.

Replacement prosthetic devices that temporarily or permanently replace all or part of an external body part lost or impaired as a result of disease or injury or congenital defects are covered, when such devices are prescribed by a **Participating Provider** and authorized in advance 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.

P. **Injectable Medications Benefits.**

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

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

Q. **Infertility Services.**

Infertility services are covered upon prior authorization by **HMO** when provided by a **Participating Provider**. Benefits include, but are not limited to, services to diagnose and treat the underlying medical cause of **Infertility** which are furnished to a **Member**.

R. **Temporomandibular Joint Dysfunction.**

Temporomandibular Joint Dysfunction services are covered upon prior authorization by **HMO** when provided by a **Participating Provider**. Benefits include, but are not limited to the following:

1. Surgical treatment for the correction of Temporomandibular Joint Dysfunction;

2. Surgical and non-surgical treatment for the correction of functional deformities of the maxilla and mandible. Non-surgical treatment is limited to history and examination, radiographs to diagnose Temporomandibular Joint Dysfunction; splint therapy with necessary adjustments; use of intraoral prosthetic appliances to reposition the bones; and diagnostic or therapeutic mastricatory muscle and Temporomandibular Joint injections.

S. **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**, a maximum annual out-of-pocket payment, and a maximum annual 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 preauthorized 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 preauthorization by **HMO**. Replacement, repairs and maintenance are covered only if it is demonstrated to the **HMO** that:

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

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

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

  A **Copayment**, a maximum annual out-of-pocket payment, and a maximum annual 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 a rider attached to this **Certificate**:

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

- Beam neurologic testing.

- Biofeedback, except as specifically approved 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 law require to be treated in a public facility.

- 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 when performed within 2 years of the event 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. This exclusion does not apply to mastectomy and breast reconstruction after mastectomy. Reconstruction following a mastectomy is covered without regard to the lapse of time between mastectomy and reconstruction.

- 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, prosthetic restoration of dental implants, and dental implants. This exclusion does not include bony impacted teeth, bone fractures, removal of tumors, and orthodontogenic cysts. This exclusion does not apply to surgical and non-surgical treatment of TMJ as outlined in the Covered Benefits section.

- 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 approved by **HMO** prior to the treatment being rendered.

  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.

- False teeth.

- Family planning services.

- Hair analysis.

- Hearing aids.

- Health 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**.

- 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 specifically approved by **HMO**.

- Implantable drugs.

- **Infertility** services, including the treatment of male and female **Infertility**, injectable **Infertility** drugs, charges for the freezing and storage of cryopreserved embryos, charges for storage of sperm, and donor costs, including but not limited to, the cost of donor eggs and donor sperm, the costs for ovulation predictor kits, and the costs for donor egg program or gestational carriers.

- 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, including any charge incurred for a missed appointment with a **Participating Provider**.

- 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.

- Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision).

- Orthotics.

- Outpatient prescription or non-prescription drugs and medicines.
- Outpatient supplies, including but not limited to, outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings, and reagent strips.
- Payment for benefits for which Medicare or a third party payer 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.
- Private duty or special nursing care, unless pre-authorized by **HMO**.
- Radial keratotomy, including related procedures designed to surgically correct refractive errors.
- Recreational, educational, and sleep therapy, including any related diagnostic testing.
- Rehabilitation services, for **Substance Abuse**, including treatment of chronic alcoholism or drug addiction.
- 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 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 specifically approved by **HMO**.

- Therapy or rehabilitation, including but not limited to, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, vision perception training, and carbon dioxide.

- Thermograms and thermography.

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

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

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

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

- Treatment of spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or dislocation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of, or related to, distortion, misalignment, or dislocation of or in the vertebral column.

- Unauthorized services, including any service obtained by or on behalf of a **Member** without prior **Referral** issued by the **Member's PCP** or certified by **HMO**. This exclusion does not apply in a **Medical Emergency**, in an **Urgent Care** situation, or when it is a direct access benefit.

- Vision care services and supplies.

- 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.

Limitations.

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

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

DETERMINATIONS REGARDING DENIAL OF BENEFITS DUE TO INAPPROPRITE 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 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 on the Schedule of Benefits;

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

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

Coverage for a dependent child covered under a qualified medical support order as set forth in this **Certificate** may not be terminated unless written evidence is provided to **HMO** that:

1. the order is no longer in effect; or

2. the child has been or will be enrolled under other reasonable health insurance coverage which will take effect not later than the effective date of the disenrollment; or

3. the **Contract Holder** has eliminated family health coverage for all of its employees; or

4. the **Contract Holder** no longer employs the parent under whose name the child has been enrolled for coverage except to the extent that if the parent elects to exercise the provision of the Consolidated Omnibus Budget Reconciliation act of 1985 (COBRA) then coverage will be provided for the **Covered Dependent** consistent with the **Contract Holder's** plan relating to postemployment medical coverage for dependents.

C. **Termination For Cause.**

HMO may terminate coverage for cause:

1. subject to the Grievance Procedure described in this **Certificate**, 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**. Notice shall be given by certified mail and return receipt requested. At 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 with **HMO** as required by the **Group Agreement**.

4. immediately, upon discovering a material misrepresentation by the **Member** in applying for or obtaining coverage or benefits under this **Certificate** or discovering that the **Member** has committed 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.

5. 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**.

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

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

In the event that **HMO** decides to discontinue offering a particular type of group health coverage, the **HMO** shall notify the **Contract Holder** and the **Members** covered by such coverage of the discontinuation at least 90 days before the date of discontinuation of coverage. The **HMO** shall offer any other type of coverage that is currently available to those **Contract Holders**.

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 provide the certification (i) at the time a **Member** ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision, (ii) in the case of a **Member** becoming covered under a COBRA continuation provision, at the time the **Member** ceases to be covered under the COBRA continuation provision, and (iii) on the request on behalf of a **Member** made not later than 24 months after the date of cessation of the coverage described in (i) or (ii), whichever is later.

The certification under clause (i) may be provided to the extent practicable at a time consistent with notice required under any applicable COBRA continuation provision.

CONTINUATION AND CONVERSION

A. **COBRA Continuation Coverage.**

COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986. This Act permits **Members** or **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 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 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** before the end of the initial 18-month period, continuation coverage may be extended up to an additional 11 months for a total of 29 months. This provision is limited to **Members** who are disabled at any time during the first 60 days of continuation coverage under this subsection (A) and only when the qualifying event is the **Members** reduction in hours or termination. The **Member** may be charged a higher rate for the extended period.

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

   The **Contract Holder** is responsible for providing the necessary notification to **Members**, within the defined time period (sixty (60) days), as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986.

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

   Coverage for the sixty (60) day period as described above to initially enroll, will be extended only where the **Subscriber** or **Member** pays the applicable **Premium** charges due within forty-five (45) days of submitting the application to the **Contract Holder** and **Contract Holder** in turn remitting same to **HMO**.

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 North Carolina Law.**

1. A **Member** who would otherwise lose coverage may continue uninterrupted coverage under this **Certificate** for up to eighteen (18) months with the **Contract Holder** if the **Member** resides in the **HMO Service Area** and

   a. **Member's** coverage is through a **Subscriber** whose employment involuntarily terminates. Continuation shall only be available to a **Member** who has been continuously covered under this **Certificate** or under a similar group benefit plan which this **Certificate** replaced, during the period of three consecutive months immediately prior to the date of termination.

   b. Continuation shall not be available to any **Member** who is or could be covered by any other arrangement of hospital, surgical, or medical coverage for individuals in a group, whether insured or uninsured, within 31 days immediately following the date of termination; or whose coverage terminated because **Member** failed to pay any required contribution for the coverage.

   c. The **Member** must notify the **Contract Holder** in writing on the form provided by **HMO** of the continuation election within thirty-one (31) days of the date coverage terminated or thirty-one (31) days from the date of notification of the continuation privilege, whichever is later. Coverage under this section will continue only upon payment of the applicable **Premium** to the **Contract Holder** at the time specified by the **Contract Holder** and will terminate the earliest of:

      1) The date the **Group Agreement** is terminated;
      2) The date **Member** is eligible to become covered for similar benefits under any arrangement of coverage for individuals in a group, whether insured or uninsured;
      3) The date **Member** is entitled to Medicare benefits;
      4) **Member** ceases to qualify as a dependent child as described in this **Certificate**;
      5) The date ending the period for which the **Member** last makes his required contribution, if **Member** discontinues his contributions; or
      6) Expiration of 18 calendar months after the termination of employment.

   d. An individual who resides in the **HMO Service Area** and who previously had continued group coverage with a health benefits carrier or health maintenance organization, other than **HMO** will become eligible to continue group coverage with **HMO**, if the **Contract Holder** changes to this **HMO** Plan, or, the **Subscriber** changed to this **HMO** Plan, such individual may enroll in **HMO** and continue coverage as set forth in this **Certificate**.

2. **Premiums** payable to **HMO** for the continuation of coverage under this Section shall be due in accordance with the procedures of the **Group Agreement** and shall be calculated in accordance with applicable federal law and regulations and North Carolina State Law.

C. **Continuation of Coverage by HMO.**

In the event a **Subscriber's** employment with **Contract Holder** is terminated involuntarily and without cause, **Subscriber** shall be entitled to continue coverage, including coverage of **Covered Dependents**, immediately thereafter, without payment of additional **Premium**, for a period equal to one month (i.e., the corresponding day of the following month, for example from February 15th to March 15th) for each year that **Subscriber** has continuously (i.e., no lapse of more than thirty (30) days) maintained coverage with **HMO** under an eligible **Group Agreement**, commencing with the date that **Subscriber** is effective under this section, to a maximum of three months of such coverage. All continued coverage utilized by **Subscriber** pursuant to this section shall be deducted from **Subscriber's** accumulated eligibility for continued coverage under this subsection (i.e., if **Subscriber** has used one (1) month of a three (3) month

accumulated continued coverage period, two (2) months will remain until such time as **Subscriber** again becomes eligible for three (3) months of continued coverage.) To be eligible for and obtain such continued coverage an application must be received by **HMO** within thirty (30) days after **Subscriber's** termination of employment and shall include (x) a signed representation from the **Subscriber** that the **Subscriber** is not eligible for other comprehensive group health coverage (such as through a spouse or other employer) or Medicare, and (y) a signed written certification from the **Contract Holder** that the **Subscriber's** employment was terminated involuntarily and without cause. In the event **Subscriber** exercises **Subscriber's** COBRA or other continuation rights under this **Certificate**, continuation of coverage hereunder shall be in the form of the waiver of the applicable COBRA **Premium** or other continuation **Premium**.

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 one of the following reasons:

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

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

c. A **Covered Dependent** ceased to meet the eligibility requirements as described in the Eligibility and Enrollment section of this **Certificate** because of the **Member's** age or the death or divorce of **Subscriber**; or

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

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

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

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

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

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

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

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

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

5. 18 months from the termination date of the **Group Agreement**.

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.

UTILIZATION REVIEW PROCEDURE

A. **Definitions.**

1. A "clinical peer" is a health care professional who holds an unrestricted license in a state in the United States, in the same or similar specialty and routinely provides the health care services subject to utilization review.

2. "Clinical review criteria" is the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by an **HMO** to determine **Medically Necessary** services and supplies.

3. A "**Medical Emergency**" is a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

   i. placing the health of an individual or with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;

   ii. serious impairment to bodily functions;

   iii. serious dysfunction of any bodily organ or part.

4. "Emergency services" are health care items and services furnished or required to screen for or treat a **Medical Emergency** until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department.

5. "Health care services" are services provided for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

6. A "managed care plan" is a health benefit plan in which an **HMO** either (i) requires a **Member** to use or (ii) creates incentives, including financial incentives, for a **Member** to use **Providers** that are under contract with or managed, owned or employed by the **HMO**.

7. "Noncertification" is a determination by an **HMO** or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and based upon the information provided, does not meet the **HMO's** requirements for **Medical Necessity**, appropriateness, health care setting, level of care or effectiveness and the requested service is therefore denied, reduced or terminated. A noncertification is not a decision rendered solely on the basis that the **HMO** does not provide benefits for the health care service in question, if the exclusion of the specific service requested is clearly stated in the certificate of coverage.

8. "Stabilize" is to provide medical care that is appropriate to prevent a material deterioration of the person's condition, within reasonable medical probability, in accordance with the HCFA interpretative guidelines, policies, and regulations pertaining to responsibilities of **Hospital** in emergency cases including **Medically Necessity** services and supplies to maintain stabilization until the person is transferred.

9. "Utilization Review" is a set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities. These techniques may include:

    a. Ambulatory Review: Utilization review of services performed or provided in an outpatient setting.

    b. Case Management: A coordinated set of set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

    c. Certification: A determination by an **HMO** or its designated URO that an admission, availability of care, continued stay, or other service has been reviewed and based on the information provided, satisfies the **HMO's** requirements for **Medically Necessary** services and supplies, appropriateness, health care setting, level of care and effectiveness.

    d. Concurrent Review: Utilization review conducted during a patient's hospital stay or course of treatment.

    e. Discharge Planning: The formal process for determining, before discharge from a provider facility, the coordination and management of the care that a patient receives after discharge from a provider facility.

    f. Prospective Review: Utilization review conducted before an admission or a course of treatment including any required preauthorization or certification.

    g. Retrospective Review: Utilization review of **Medically Necessary** services and supplies that is conducted after services have been provided to a patient, but not the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

h. Second Opinion: An opportunity or requirement to obtain a clinical evaluation by a **Provider** other than the **Provider** originally making a recommendation for a proposed service to assess the clinical necessity and appropriateness of the proposed service.

i. Utilization Review Organization or URO: is an entity that conducts utilization review under an **HMO**, but does not mean an **HMO** performing utilization review for its own health benefit plan.

B. **HMO Oversight.**

Every **HMO** shall monitor all utilization review carried out by or on behalf of the **HMO** and ensure compliance. An **HMO** shall ensure that appropriate personnel have operational responsibility for the conduct of the **HMO's** utilization review program. If an **HMO** contracts to a URO perform its utilization review, the **HMO** shall monitor the URO to ensure compliance which shall include:

1. A written description of the URO's activities and responsibilities, including reporting requirements.

2. Evidence of formal approval of the utilization review organization program by the **HMO**.

3. A process by which the **HMO** evaluates the performance of the URO.

C. **Scope and Content of Program.**

1. Procedures to evaluate the clinical necessity, appropriateness, efficacy, of efficiency of health services.

2. Data sources and clinical review criteria used in decision making.

3. The process for conducting appeals for noncertifications.

4. Mechanisms to ensure consistent application of review criteria and compatible decisions.

5. Data collection processes and analytical methods used in assessing utilization of health services.

6. Provisions for assuring confidentiality of clinical and patient information in accordance with State and federal law.

7. The organization structure that periodically assesses utilization review activities and reports to the **HMO's** governing body.

8. The staff position functionally responsible for day-to-day program management.

9. The methods of collection and assessment of data about underutilization and overutilization of health care services and how the assessment is used to evaluate and improve procedures and criteria for utilization review.

D. **Program Operations.**

In every utilization review program, an **HMO** or URO shall use documented clinical review criteria that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficiency. An **HMO** may develop its own clinical review criteria or purchase or license review criteria. Qualified health care professionals shall administer the utilization review program and oversee review decisions under the direction of a medical doctor. A medical doctor shall evaluate the clinical appropriateness of

noncertifications. Compensations to persons involved in utilization review shall not contain any direct or indirect incentives for them to make any particular review decisions. Compensation to utilization reviewers shall not be directly or indirectly based on the number or type of noncertifications they render. In issuing a utilization review decision, an **HMO** shall: obtain all available information required to make the decision, including all pertinent clinical information; employ a process to ensure that utilization reviewers apply clinical review criteria consistently; and issue the decision in a timely manner.

E. **HMO Responsibilities.**

1. Routine assess the effectiveness and efficiency of its utilization review program.

2. Coordinate the utilization review program with its other medical management activity, including quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for assessing satisfaction of **Members** and risk management.

3. Provide **Members** and their providers with access to its review staff by a toll-free or collect call telephone number whenever any **Provider** is required to be available to provide services which may require prior certification to any plan **Member**. Every **HMO** shall establish standards for telephone accessibility and monitor telephone service as indicated by average speed of answer and call abandonment rate on at least a month-by-month basis, to ensure that telephone service is adequate and take corrective action when necessary.

4. Limit its requests for information to only that information that is necessary to certify the admission, procedure or treatment, length of stay, and frequency and duration of health care services.

5. Have written procedures for making utilization review decisions and for notifying **Members** of those decisions.

6. Have written procedures to address the failure or inability of a **Provider** or **Member** to provide all necessary information for review. If a **Provider** or **Member** fails to release necessary information in a timely manner, the **HMO** may deny certification.

F. **Prospective and Concurrent Reviews.**

Necessary information includes the results of any patient examination, clinical evaluation, or second opinion that may be required. Prospective and concurrent determinations shall be communicated to the **Member's** provider within three business days after the **HMO** obtains all necessary information about the admission, procedure or health care service. If an **HMO's** certifies a health care service, the **HMO** shall notify the **Member's Provider**. For a noncertification, the **HMO** shall notify the **Member's Provider** and send written or electronic confirmation of the noncertification to the **Member**. In concurrent reviews, the **HMO** shall remain liable for health care services until the **Member** has been notified of the noncertification.

G. **Retrospective Reviews.**

Necessary information includes the results of any patient examination, clinical evaluation or second opinion that may be required. For retrospective review determinations, an **HMO** shall make the determination within thirty (30) days after receiving all necessary information. For a certification, the **HMO** may give written notification to the **Member's Provider**. For a noncertification, the **HMO** shall give written notification to the **Member's Provider** within five (5) business days after making the noncertification.

H. **Notice of Noncertification.**

A written notification of a noncertification shall include all reasons for the noncertification, including the clinical rationale, the instructions for initiating a voluntary appeal or reconsideration of the noncertification, and the instructions for requesting a written statement of the clinical review criteria used to make the noncertification. An **HMO** shall provide the clinical review criteria used to make the noncertification to any person who received the notification of the noncertification and who follows the procedures for a request.

I. **Requests for Reconsideration.**

An **HMO** may establish procedures for informal reconsideration of noncertifications. The reconsideration shall be conducted between the **Member's Provider** and a medical doctor designated by the **HMO**. An **HMO** shall not require a **Member** to participate in an informal reconsideration before the **Member** may appeal a noncertification.

J. **Appeals of Noncertification.**

Every **HMO** shall have written procedures for appeals of noncertifications by **Members** or their **Providers** acting on their behalves, including expedited review to address a situation where the time frames for the standard review procedures would reasonably appear to seriously jeopardize the life or health of a **Member** or jeopardize the **Member's** ability to regain maximum function. Each appeal shall be evaluated by a medical doctor who was not involved in the noncertification.

K. **Nonexpedited Appeals.**

Within three (3) business days after receiving a request for a standard, nonexpedited appeal, the **HMO** shall provide the **Member** with the name, address, and telephone number of the coordinator and information on how to submit written material. For standard, nonexpedited appeals, the **HMO** shall give written notification of the decision to the **Member** and the **Member's Provider** within thirty (30) days after the **HMO** receives the request for an appeal. The written decision shall contain:

1. The professional qualifications and licensure of the person or persons reviewing the appeal.

2. A statement of the reviewers' understanding of the reason for the **Member's** appeal.

3. The reviewers' decision in clear terms and the medical rationale in sufficient detail for the **Member** to respond further to the **HMO's** position.

4. A reference to the evidence or documentation that is the basis for the decision, including the clinical review criteria used to make the determination and instructions for requesting the clinical review criteria.

5. A statement advising the **Member** of the **Member's** right to request a second level grievance review and a description of the procedure for submitting a second level grievance.

L. **Expedited Appeals.**

An expedited appeal of a noncertification may be requested by a **Member** or his or her **Provider** acting on the **Member's** behalf only when the nonexpedited appeal would reasonably appear to seriously jeopardize the life or health of a **Member** or jeopardize the **Member's** ability to regain maximum function. The **HMO** may require documentation of the medical justification for the expedited appeal. The **HMO** shall, in conjunction with a medical doctor provide expedited review and the **HMO** shall communicate its decision in writing to the **Member** and his or her **Provider** as soon as possible, but not later than four (4) days after receiving the information justifying expedited review. The written decision shall contain the provision

listed in section K above. If the expedited review is a concurrent review determination, the **HMO** shall remain liable for the coverage of health care services until the **Member** has been notified of the determination. An **HMO** is not required to provide an expedited review for retrospective noncertifications.

M. **Disclosure Requirements.**

In the Certificate of Coverage and member handbook provided to **Members**, an **HMO** shall include a clear and comprehensive description of its utilization review procedures, including the procedures for appealing noncertifications and a statement of the rights and responsibilities of **Members**, including the voluntary nature of the appeal process, with respect to hose procedures. An **HMO** shall include a summary of its utilization review procedures in materials intended for prospective **Members**. An **HMO** shall print on its membership cards a toll-free telephone number to call for utilization review purposes.

N. **Maintenance of Records.**

Every **HMO** and URO shall maintain records of each review performed and each appeal received or reviewed, as well as documentation sufficient to demonstrate compliance. The maintenance of these records, including electronic reproduction and storage shall be governed by rules adopted by the Commissioner that apply to **HMO's**. These records shall be retained by the **HMO** and the URO for a period of three (3) years or until the Commissioner has adopted a final report of a general examination that contains a review of these records for that calendar year, which ever is later.

GRIEVANCE PROCEDURE

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

A. **Definitions.**

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

2. A "grievance" is a written complaint voluntarily submitted by the **Member** or by the **Member's Provider** on the **Member's** behalf to the **HMO** about any of the following:

   i. **HMO's** decisions, policies or actions related to the availability, delivery or quality of health care services;

   ii. claims payment or handling; or reimbursement for services;

   iii. the contractual relationship between **HMO** and **Member**;

   iv. the outcome of an appeal of a noncertification.

B. **Grievance Review.**

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

   i. acknowledging each grievance; and
   ii. inviting the **Member** to provide any additional information to assist **HMO** in handling and deciding the grievance; and
   iii. informing the **Member** of the **Member's** right to have an uninvolved **HMO** representative assist the **Member** in understanding the grievance process; and
   iv. informing the **Member** as to when a response should be forthcoming; and

v. within three (3) business day, the **HMO** shall provide the **Member** with the name, address and the telephone number of the coordinator and information on how to submit written material.

2. The Grievance Committee deciding the grievance shall be comprised of one or more employees of **HMO**. It shall not include any person whose decision is being appealed, any person who made the initial decision regarding the claim, or any person with previous involvement with the grievance. If the grievance is a clinical issue, at least one of whom shall be a medical doctor with appropriate expertise to evaluate the matter. The Grievance Committee shall review and decide the grievance within 30 days of receipt unless additional information necessary to resolve the grievance is not received during such time, or by the mutual written agreement of **HMO** and the **Member**.

3. A written notice stating the result of the review by the Grievance Committee shall be forwarded by **HMO** to the **Member** within ten (10) working days of the date of the decision. Such notice shall include:

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

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

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

d. a statement indicating:

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

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

e. that the decision of the Grievance Committee shall be final and binding unless appealed by the **Member** to **HMO** within thirty (30) days of the date of the notice of the decision of the Grievance Committee; and

f. the professional qualifications and licensure of the person or persons reviewing the grievance.

C. **Appeal Hearing.**

1. Upon receipt of a written appeal by a **Member** to the Grievance Appeal Committee or upon request by a **Member** for review of non-certifications by **HMO**, **HMO** shall provide the **Member** filing the appeal with the procedures governing appeals before the Grievance Appeal Committee. The **Member** shall be notified of the **Member's** right to have an uninvolved **HMO** representative available to assist the **Member** in understanding the appeal process.

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

3. The Grievance Appeal Committee shall hold appeal hearings in **HMO** offices on a certain day each month to consider all appeals filed seven business days or more in advance of the hearing day. In the event a **Member** is unable to attend the hearing on the scheduled hearing day, the **Member** may request that their appeal be heard on the next scheduled hearing day. If no scheduled hearing day is suitable for the **Member**, the hearing will be scheduled for the following month.

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

5. The appeal hearing shall be informal. The Grievance Appeal Committee shall not apply formal rules of evidence in reviewing documentation or accepting testimony at the hearing. The Chair of the Grievance Appeal Committee shall have the right to exclude redundant testimony or excessive argument by any party or witness.

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

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

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

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

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

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

    d. a statement of the **Member's** right to appeal to the Department of Insurance, with the phone number and complete address of the Department of Insurance.

D. The North Carolina Department of Insurance is available to assist consumers with insurance related problems and questions. You may inquire in writing to the Department at P.O. box 26387, Raleigh, NC 27611 or by telephone at 1-800-546-5664.

E. **Emergency or Urgently Needed Care.**

1. In the event a complaint requires specific action, and the **Member** or **HMO** believes serious medical consequences will arise in the near future, or the **Member's** ability to regain maximum function is jeopardized, the **Member** may request an expedited review of their complaint. The **HMO** in consultation with an **HMO Medical Director** shall provide an expedited review and **HMO** shall communicate its decision in writing to the **Member** and the **Member's Provider** within 4 days after receiving information justifying the expedited appeal. If the expedited review is a concurrent review determination, **HMO** shall remain liable for the coverage of health care services until the **Member** has been notified of the determination. **HMO** is not required to provide an expedited review for retrospective noncertifications.

2. In the event the issue is of an emergent nature, an **HMO** Medical Director shall review the matter as soon as possible or within 48 hours, and communicate a decision to the **Member** by telephone.

3. In the event the issue is of an urgent nature, an **HMO** Medical Director shall review the matter and make a determination within 96 hours of receipt.

4. An adverse decision by a Medical Director in either an emergent or urgent medical situation shall be immediately reviewed by an **HMO** Regional Medical Director or his designee. The decision of the Regional Medical Director shall be provided to the **Member** by telephone and confirmed in writing.

F. **Record Retention.**

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

G. **Fees and Costs.**

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

COORDINATION OF BENEFITS

Some **Members** have health coverage in addition to the coverage provided under this **Certificate**. When this is the case, the benefits paid by other plans will be taken into account. This may mean a reduction in benefits payable under this **Certificate**.

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

B. 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.

C. 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 (C) 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.

D. 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 (C) 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.

E. If A, B, C and D 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.

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. True group insurance. This includes prepayment, group practice or individual practice coverage. It does not include school accident-type coverage, blanket, franchise individual, automobile and homeowner coverage.

2. Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its benefits are excess to those of any private insurance company or other non-governmental program.

Payment of Benefits.

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

The difference between the cost of a private **Hospital** room and the semiprivate rate is not considered an **Allowable Expense** unless the patient's stay in a private **Hospital** room is **Medically Necessary**, either in terms of generally accepted medical practice or as specifically defined in this **Certificate**.

When the benefits under the plan which determines its benefits first are reduced because a **Member** does not comply with the plan provisions, the amount of such reduction will not be considered an **Allowable Expense**. Examples of such provisions include, but are not limited to, those related to second surgical opinions and certification of admissions or services.

Facility of Payment.

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

Recovery of Overpayments.

If the benefits paid under this **Certificate**, plus the benefits paid by other plans, exceeds the total amount of **Allowable Expenses**, **HMO** has the right to recover the amount of that excess payment if it is the Secondary Plan, from among one or more of the following: (1) any person to or for whom such payments were made; (2) other plans; or (3) any other entity to which such payments were made. This right of recovery shall be exercised at **HMO's** discretion. This recovery shall not include any liability settlements. 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** determines 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 **Dependents** who are eligible for Medicare. When a active **Subscriber**, or the **Dependent** of a active **Subscriber**, is eligible for Medicare and the **Subscriber** or **Dependent** belongs to a group covered by this **Certificate** with twenty (20) or more employees, that **Member** must make a written election to the **Contract Holder** indicating whom that **Member** wants to be his primary carrier. If the **Member** elects the **Contract Holder's** group plan as the primary plan, this **Certificate** will be the primary payer. If the **Member** elects Medicare as the primary plan, all benefits otherwise payable to that **Member** under this **Certificate** shall terminate. If the **Member** belongs to a covered group of less than twenty (20) employees, this **Certificate** will be secondary payer and all benefits otherwise payable with respect to the **Member** will be paid in accordance with the Provision for Coordination with Medicare section below.

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

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

Provision for Coordination with Medicare.

HMO reserves the right to cover full benefits or to reduce benefits for any medical expenses covered under this **Certificate**. The amount **HMO** will pay will be figured so that the amount, plus the benefits under Medicare, will equal no more than 100% of plan expenses. Plan expenses means any necessary medical expenses and reasonable charges, part or all of which are covered under **HMO**. Charges for services used to satisfy a **Member's** Medicare Part B deductible will be applied under this **Certificate** in the order received by **HMO**. Two or more charges for services received at the same time will be applied starting with the largest first. Any rules for **Coordination of**

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

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 **Member's Covered Dependents**.

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 hereof.

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 set forth in the Grievance Procedure section of 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 set forth in the Grievance Procedure section of 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 even prior to the expiration of 60 days after written submission of claim has been furnished in accordance with requirements set forth in this **Group Agreement**. No action shall be brought after the expiration of (3) three years after the time written submission of claim is required to be furnished.

F. **Independent Contractor Relationship.**

1. No **Participating Provider** or other **Provider**, institution, facility or agency is an agent or employee of **HMO**. Neither **HMO** nor any **Member** of **HMO** is an agent or employee of any **Participating Provider** or other **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 thirty days of the termination of a **PCP** contract to each affected **Subscriber**, if the **Subscriber** or any **Dependent** of the **Subscriber** is currently enrolled in the **PCP's** office; and

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

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

G. **Inability to Provide Service.** In the event that 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 rendition of medical or **Hospital** benefits or other services provided under this **Certificate** is delayed or rendered impractical, **HMO** shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid **Premiums** held by **HMO** on the date such event occurs. **HMO** is required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

H. **Confidentiality.** Information contained in the medical records of **Members** and information received from **Physicians**, surgeons, **Hospitals** or other **Health Professionals** incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential in accordance with applicable law. Information may not be disclosed without the consent of the **Member** except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary by **HMO** in connection with the administration of this **Certificate**, or in the compiling of aggregate statistical data.

I. **Limitation on Services.** Except in cases of a **Medical Emergency**, as provided under the Covered Benefits section of this **Certificate**, services are available only from **Participating Providers**. **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.

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; and there are no warranties, representations, or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth herein. 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.

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:

- **Actively at Work.** The condition where an employee is performing all of the **Subscriber's** regular duties for the **Contract Holder** (the **Subscriber's** employer) on a regularly scheduled work day, at the location where such duties are normally performed, and on a full-time basis. An employee will be considered to be **Actively at Work** on a non-scheduled work day only if such person is **Actively at Work** on the last regularly scheduled work day immediately preceding such non-scheduled work day.

- **Allowable Expense.** Any necessary and reasonable health expense, part or all of which is covered under any of the plans covering the **Member** for whom claim is made.

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

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

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

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

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

- **Copayment.** A 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**, if any.

- **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. A self-funded employer group health plan under the Employee Retirement Income Security Act of 1974.
  b. Group or individual health insurance coverage.
  c. Part A or part B of Title XVIII of the Social Security Act.
  d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928.
  e. Chapter 55 of Title 10, United States Code.
  f. A medical care program of the Indian Health Service or of a tribal organization.
  g. A State health benefits risk pool.
  h. A health plan offered under Chapter 89 of Title 5, United States Code.
  i. A public health plan (as defined in federal regulations).
  j. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. º 2504(e)).
  k. The Health Insurance Program for Children established in Part 8 of Chapter 108A of the General Statutes, or any successor program.

  Creditable coverage does not include coverage consisting solely of coverage of excepted benefits.

- **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 includes, but is 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.** Equipment, as determined by **HMO**, which is a) made to withstand prolonged use; b) made for and mainly used in the treatment of a disease or injury; 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, Cover Sheet, this **Certificate**, the Schedule of Benefits, any Riders, any amendments, any endorsements, and any attachments, as subsequently amended by operation of law and as filed with and approved by the applicable public authority.

- **Health Professionals.** 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.

- **HMO.** Aetna Health Inc., a North Carolina corporation licensed by the North Carolina Department of Insurance as a Health Maintenance Organization subject to Article 67 of Chapter 58.

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

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

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

- **Hospital.** 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 one 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.

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

- **Medical Emergency.** Services to treat a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

  a. placing the health of the person afflicted with such condition or with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; or

  b. serious impairment to such person's bodily functions; or

  c. serious dysfunctions of any bodily organ or part of such person; or

  d. serious disfigurement of such person.

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

- **Medically Necessary, Medically Necessary Services, or Medical Necessity.** Services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards as described in the Covered Benefits section of this **Certificate**. **Medical Necessity**, when used in relation to services, shall have the same meaning as **Medically Necessary Services**.

- **Member.** 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 or in any way resulting from chemical imbalance, physical trauma, or a physical or medical condition.

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

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

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

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

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

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

- **Primary Care Physician.** 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.** A **Physician**, **Health Professional**, **Hospital**, **Skilled Nursing Facility**, home health agency or other recognized entity or person licensed, registered or certified under Chapter 90 of the General Statutes 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.** A **Physician** who provides medical care in any generally accepted medical or surgical specialty or subspecialty.

- **Stabilize.** To provide medical care that is appropriate to prevent a material deterioration of the **Member's** condition, within reasonable medical probability, in accordance with HCFA (Health Care Financing Administration) interpretative guidelines, policies, and regulations pertaining to responsibilities of **Hospitals** in emergency cases, including **Medically Necessary** services and supplies to maintain stabilization until the **Member** is transferred.

- **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. Covered Benefits** required in order to prevent serious deterioration of a **Member's** health that results from an unforeseen illness or injury if the **Member** is temporarily absent from the **HMO Service Area** and receipt of the health care service cannot be delayed until the **Member's** return to the **Service Area**.

Aetna Health Inc.
(North Carolina)

URGENT CARE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The **Certificate** is hereby amended as follows:

1. The definition of **Urgent Care**, found in the Definitions section of the **Certificate,** is hereby deleted and replaced by the following:

   - **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.

2. The **Urgent Care** provision of Emergency Care/Urgent Care Benefits, found in the **Covered Benefits** section of the **Certificate**, is hereby deleted and replaced with the following:

   Urgent Care.

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

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

AETNA HEALTH INC.
(NORTH CAROLINA)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

A. **Diagnostic Services.**

The following is added to the Diagnostic Services section:

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

- Qualified **Members** must meet one or more of the following criteria:

  a. **Member** is estrogen deficient and at clinical risk of osteoporosis or low bone mass;
  b. **Member** has radiographic osteopenia anywhere in the skeleton;
  c. **Member** is receiving long-term glucocorticoid (steroid) therapy;
  d. **Member** has primary hyperthyroidism;
  e. **Member** is being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies;
  f. **Member** has a history of low trauma bone fractures; or
  g. **Member** has another condition or is on medical therapies known to cause osteoporosis or low bone mass.

- Bone mass measurement will be covered if at least 23 months has elapsed since the last bone mass measurement was performed. Coverage will be provided for follow-up bone mass measurement performed more frequently than every 23 months if **Medically Necessary**.

B. **Additional Benefits.**

- **Contraceptives.**

  Insertion and removal of contraceptive devices by a **Participating Physician**, subject to applicable **Copayment**.

AETNA HEALTH INC.
(NORTH CAROLINA)

CERTIFICATE OF COVERAGE AMENDMENT

Group Agreement Effective Date: January 1, 2013

The **Certificate** is hereby amended as noted below.

1. The following item is added to the "**HMO Procedure**" section:

   G. **Continuity of Care for An Ongoing Special Condition.**

   Current **Members**: Any **Member** who had filed a claim for benefits or is receiving care from a **Participating Provider** for an **Ongoing Special Condition** at the time the **Provider's** contract with the **HMO** terminates, the **Member** may elect to continue to receive care from the **Provider** if the **Provider** agrees, in writing, with regard to continuing treatment of the **Member** during the **Member's Transitional Period**, to continue to abide by the terms of the terminating contract with the **HMO**. The **HMO** will provide written notice to the **Member** when the **Participating Provider's** contract with the **HMO** terminates.

   Newly Enrolled **Members**: Any newly enrolled **Member** who or is receiving care from a **Provider** for an **Ongoing Special Condition** at the time of enrollment may elect to continue to receive care from the **Provider** if the **Provider** agrees, in writing, with regard to continuing treatment of the **Member** during the **Member's Transitional Period**: (1) to be compensated at the same rate as similar **Participating Providers** in the same or similar geographic area, and to accept any applicable **Copayment** as reimbursement in full from the **HMO** and the **Member** for all **Covered Benefits;** and (2) to abide by the **HMO's** established processes, procedures, including procedures regarding **Referrals**, precertification of certain **Covered Benefits** and quality management. The newly enrolled **Member** will be notified at the time of enrollment of the option to continue to receive care from the **Provider**. The **Member** must notify the **HMO** within 45 days of such notice that the **Member** will elect to continue to receive treatment from the **Provider**.

2. The "**Transplants**" item of the "**Covered Benefits"** section is replaced by the following:

   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 approved by **HMO's** Medical Director in advance of the surgery. The transplant must be performed at **Hospitals** specifically approved and designated by **HMO** to perform these procedures. Travel and lodging expenses are covered for the **Member** and for the parent or guardian when accompanying a minor for a transplant procedure outside the service area. A transplant is non-experimental and non-investigational hereunder when it a part of an **Eligible Clinical Trial** or 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.

3. The "**Covered Benefits**" section is amended to add Evidence of Coverage section the following notice:

   "NOTICE: Your actual expenses for covered services may exceed the stated (coinsurance percentage or co-payment amount) because actual provider charges may not be used to determine (plan/insurer or similar term) and (insured/member/enrollee or similar term) payment obligations."

4. The "**Covered Benefits**" section is amended to add the following to the "**Emergency Care/Urgent Benefits**" section:

"When a member utilizes a non-Participating provider for the provision of emergency room or urgent care service, the Provider may submit its bill directly to the **HMO** for payment."

5. The "**Experimental or Investigational Procedures**" exclusion, in the "**Exclusions**" section is replaced by the following:

Experimental or **Investigational Procedures**, or ineffective surgical, medical, psychiatric, or dental treatments or procedures, research studies, or other experimental or investigational health care procedures, (other than **Eligible Clinical Trials**) or pharmacological regimes as determined by **HMO**, unless approved by **HMO** prior to the treatment being rendered.

This exclusion will not apply with respect to drugs:

- that have been granted treatment investigational new drug (IND) or Group c/treatment IND status;
- that are being studied under an **Eligible Clinical Trial**; or
- **HMO** has determined that available scientific evidence demonstrates that the drug is effective or the drug shows promise of being effective for the disease.

6. The outpatient prescription or non-prescription drugs and medicines exclusion, shown in the "**Exclusions"** section, is replaced by the following:

Outpatient prescription or non-prescription drugs and medicines. This exclusion does not apply to drugs and medicines necessary for the treatment of diabetes, as outlined in the **Covered Benefits** section of the **Certificate**.

7. The injectable drugs exclusion is deleted from "**Exclusions"** and replaced by the following:

- 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**, and performance enhancing steroids.

8. The implantable drugs exclusion is deleted from "**Exclusions"** and replaced by the following:

Implantable drugs, but not including implantable contraceptive drugs.

9. The following exclusion is deleted from the "**Exclusions"** section:

- 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. However, if proof is furnished to **HMO** that the **Member** is covered under a workers' compensation law or similar law, but is not covered for a particular disease or injury under such law, that disease or injury will be considered "non-occupational" regardless of cause.

The following exclusion is added to the "**Exclusions**" section:

- Treatment of occupational injuries and occupational diseases which are paid or payable under the North Carolina's Workers' Compensation Act but only to the extent that **Covered Services** are the liability of the **Member**, the **Contract Holder** or worker's compensation insurance carrier according to final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

10. Section B(1)(a) of "**Continuation and Conversion**" is replaced by the following:

Member's coverage is through a **Subscriber** whose employment involuntarily terminates. Continuation shall only be available to a **Member** who has been continuously covered under this **Certificate** or under a similar group benefit plan which this **Certificate** replaced, during the period of three consecutive months immediately before the date of termination. The **Subscriber** or **Member** may elect continuation for a period of not fewer than 60 days after the date of termination or loss of eligibility. The **Subscriber** or **Member** shall make the first contribution upon the election to continue coverage, and the coverage shall be retroactive to the date of termination or loss of eligibility.

11. Section E of **General Provisions**, "**Legal Action**" is replaced by the following:

E. **Legal Action.** No action at law or in equity may be maintained against **HMO** for any expense or bill prior to the expiration of 60 days after written submission of claim has been furnished in accordance with requirements set forth in this **Group Agreement**. No action shall be brought after the expiration of (3) three years after the time written submission of claim is required to be furnished.

12. Section F(4) of "**General Provisions**", "**Independent Contractor Relationship**", is replaced by the following:

4. Except as otherwise expressly outlined in this **Certificate**, **HMO** cannot guarantee or facilitate the continued participation of any **Provider** or facility with **HMO**. In the event a **Provider** terminates its contract or is terminated by **HMO**, **HMO** shall provide notification to **Members** in the following manner:

   - within thirty days of the termination of a **Provider's** contract to each affected **Subscriber**, if the **Subscriber** or any **Dependent** of the **Subscriber** is currently enrolled in the **Provider's** office or otherwise receiving care from the **Provider** for **Covered Benefits**; and

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

13. Section I of **General Provisions**, "**Limitation on Services**" is replaced by the following:

Limitation on Services. Except in cases of a **Medical Emergency**, as provided under the **Covered Benefits** section of this **Certificate**, services are available only from **Participating Providers**. **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**.

However, in the event **HMO** is unable to reasonably meet the needs of the **Member** for the provision of **Covered Benefits**, other than as outlined in item G of these **General Provisions**, "Inability to Provide Service," the **Member** may, with preauthorization from **HMO**, seek care from non-participating

Providers. The **Member** will be reimbursed by **HMO** for such care for the total amount of the **Covered Benefits**.

14. The "**Copayment**" definition, found in the "**Definitions**" section, is replaced by the following:

Copayment. A 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 45 days written notice to the **Contract Holder**. If the **Member's Copayment** is a percentage amount, that **Copayment** will be determined as illustrated below. In the case of percentage **Copayments**, **Providers** have contractually agreed with **HMO** not to bill the **Member** for amounts, which exceed the **HMO's** recognized charge, (the contracted rate agreed to by the Provider) for **Covered Benefits**. **Participating Providers** will bill the **HMO** directly for **Covered Benefits**.

	Participating Provider	Nonparticipating Provider
A. Total Bill	$5,000	$5,000
B. Allowed Amount	$4,250	$4,250
C. Deductible Amount	$ 250	$ 250
D. Allowed Amount minus Deductible (B and C)	$4,000	$4,000
E. Aetna pays	(80%) $3,200	(80%) $3,200
F. Your Coinsurance Amount (% times D)	(20%) $800	(20%) $800
G. Amount You Owe Over Allowed Amount	$1,050	$1,050

15. The following is added to the "**Definitions**" section:

Eligible Clinical Trial. A Phase II, III or IV patient research study funded by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense or the Department of Veterans Affairs which is designed to evaluate new treatments for life-threatening medical conditions. An **Eligible Clinical Trial** must have clinical and pre-clinical data that shows the trial is likely to be more effective for the **Member** than other alternatives.

16. The following is added to the "**Definition"** of "**Experimental or Investigational Procedures**" found in the "**Definitions**" section:

Eligible Clinical Trials will be not be considered either **Experimental or Investigational Procedures**.

17. The following is added to the "**Definition**" of "**Medical Necessity**" found in the "**Definitions**" section:

Eligible Clinical Trial. A Phase II, III or IV patient research study funded by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense or the Department of Veterans Affairs which is designed to evaluate new treatments for life-threatening medical conditions. An **Eligible Clinical Trial** must have clinical and pre-clinical data that shows the trial is likely to be more effective for the **Member** than other alternatives.

18. The "**Primary Care Physician**" definition, found in the "**Definitions**" section, is replaced by the following:

Primary Care Physician. A **Participating Physician** who supervises, coordinates and provides initial care and basic **Medical Services** as a general or family care practitioner, an internist, a pediatrician to **Members** under the age of 18, or as appropriate given the **Member's Serious, Chronic Illness or Condition**, a **Specialist**, and initiates their **Referral** for **Specialist** care, and maintains continuity of patient care.

19. The following is added to the "**Definitions**" section:

Ongoing Special Condition. Means:

- In the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.
- In the case of a chronic illness or condition, a disease or condition that is life-threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time.
- In the case of pregnancy, pregnancy from the start of the second trimester.
- In the case of a terminal illness, an individual has a medical prognosis that the individual's life expectancy is six months or less.

20. The following is added to the "**Definitions**" section:

Transitional Period. For continuity of care for an **Ongoing Special Condition,** this will be up to 90 days following the date of notice by the **HMO** that the **Provider's** contract will be terminating or the **Member's** date of enrollment except as otherwise noted below.

For Surgery, Transplants or Inpatient Care: Through the date of discharge for the **Member** following surgery, transplant or inpatient care and through post-discharge follow-up care occurring within 90 days after the date of discharge.
For Pregnancy: Through the provision of 60 days of postpartum care.
For Terminal Illness: If the **Member** has a prognosis for a life expectancy of six months or less, for the remainder of the **Member's** life with respect to care related to the treatment of the terminal illness or its medical manifestations.

21. The following is added to the "**Definitions**" section:

Serious, Chronic Illness or Condition. A degenerative, disabling or life-threatening disease or condition which requires specialized medical care.

22. Section A(2) of "**Definitions**" appearing in the "**Grievance Procedure**" section is expanded to include the following:

A decision rendered solely on the basis that the **Covered Benefits** do not include a particular health care service is not subject to the **HMO's** grievance procedures if an exclusion of the specific service is clearly stated in the **Certificate**.

AETNA HEALTH INC.
(NORTH CAROLINA)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Exclusions and Limitations section of the **Certificate** is hereby amended. The exclusion regarding Dental Services is deleted and replaced with the following:

- 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, prosthetic restoration of dental implants, and dental implants. This exclusion does not include bony impacted teeth, bone fractures, removal of tumors, and orthodontogenic cysts. This exclusion does not apply to surgical and non-surgical treatment of TMJ as outlined in the Covered Benefits section. In addition, this exclusion does not apply to anesthesia or **Hospital** services performed for an inpatient or outpatient dental procedure on a minor, 8 years of age or younger, **Members** with serious mental or physical conditions and **Members** with significant behavior problems, where the **Provider** treating the **Member** involved certifies that, because of the **Member's** age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedure.

AETNA HEALTH INC.
(NORTH CAROLINA)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

B. **Diagnostic Services.**

The following is added to the Diagnostic Services section:

- Colorectal Cancer Screening examinations and laboratory testing benefits are provided to **Members** as follows:

- **Member** is least 50 years of age;

  a. **Member** is less than 50 years of age and at high risk for colorectal cancer according to the most recently published American Cancer Society guidelines.

  b. when **Medically Necessary**.

AETNA HEALTH INC.
(NORTH CAROLINA)

GRIEVANCE PROCEDURE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The **Certificate** is hereby amended as follows:

The subsection C(6) of **Appeal Hearing**, located in the Grievance Procedure section is replaced by the following:

6. A written record of the appeal hearing shall be made.

AETNA HEALTH INC.
(NORTH CAROLINA)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The General Provisions section of the **Certificate** is hereby amended to add the following provision:

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.

AETNA HEALTH INC.
(NORTH CAROLINA)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

The Exclusions and Limitations section of the **Certificate** is amended to delete the following exclusion:

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

The Exclusions and Limitations section of the **Certificate** is amended to include the following exclusion:

- Costs for services resulting from the commission of, or attempt to commit a felony by the **Member**. This exclusion will not operate to deny benefits otherwise provided for treatment of an injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

AETNA HEALTH INC.
(NORTH CAROLINA)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

Cancer Benefits.

Reconstructive Breast Surgery resulting from a mastectomy is covered. Coverage includes reconstruction of the breast on which the mastectomy is performed including aereolar 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. Reconstruction of the nipple/areolar complex is covered without regard to the time that may have elapsed between this reconstruction and the actual mastectomy.

AETNA HEALTH INC.
(NORTH CAROLINA)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

Subsection B. of the **HMO** Procedure section of the **Certificate of Coverage** is hereby amended to include the following:

- In certain situations where a **Member** requires specialized medical care over a prolonged period of time, the **Member** may receive a **Referral** to a **Specialist** who will be responsible for providing and coordinating the **Member's** primary and specialty care. Please refer to the Covered Benefits section of this **Certificate** for details.

Section C. of the Covered Benefits section of the Certificate is hereby amended to include the following:

- If a **Member** requires ongoing care from a **Specialist** the **Member** may receive a standing **Referral** to such **Specialist** if **PCP** in consultation with an appropriate **Specialist** determines that a standing **Referral** shall be pursuant to a treatment plan coordinated by the **PCP**, **Specialist** and **Member**.

- A **Member** who is being treated for a life threatening condition or disease, or a degenerative and disabling condition or disease which requires specialized care over a prolonged period of time, may receive a **Referral** to a **Specialist** with expertise in treating the condition. Such **Specialist** shall be responsible for providing and coordinating the **Member's** primary and specialty care. The **HMO** shall provide the **Referral** if the **PCP** and an appropriate **Specialist** determine that the **Member's** care will be appropriately coordinated by a **Specialist**.

AETNA HEALTH INC.
(NORTH CAROLINA)

CONTINUATION OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

1. The following subsection entitled "Continuation of Coverage by **HMO**" located in the Continuation and Conversion section is hereby deleted.

   C. **Continuation of Coverage by HMO.**

   In the event a **Subscriber's** employment with **Contract Holder** is terminated involuntarily and without cause, **Subscriber** shall be entitled to continue coverage, including coverage of **Covered Dependents**, immediately thereafter, without payment of additional **Premium**, for a period equal to one month (i.e., the corresponding day of the following month, for example from February 15th to March 15th) for each year that **Subscriber** has continuously (i.e., no lapse of more than thirty (30) days) maintained coverage with **HMO** under an eligible **Group Agreement**, commencing with the date that **Subscriber** is effective under this section, to a maximum of three months of such coverage. All continued coverage utilized by **Subscriber** pursuant to this section shall be deducted from **Subscriber's** accumulated eligibility for continued coverage under this subsection (i.e., if **Subscriber** has used one (1) month of a three (3) month accumulated continued coverage period, two (2) months will remain until such time as **Subscriber** again becomes eligible for three (3) months of continued coverage.) To be eligible for and obtain such continued coverage an application must be received by **HMO** within thirty (30) days after **Subscriber's** termination of employment and shall include (x) a signed representation from the **Subscriber** that the **Subscriber** is not eligible for other comprehensive group health coverage (such as through a spouse or other employer) or Medicare, and (y) a signed written certification from the **Contract Holder** that the **Subscriber's** employment was terminated involuntarily and without cause. In the event **Subscriber** exercises **Subscriber's** COBRA or other continuation rights under this **Certificate**, continuation of coverage hereunder shall be in the form of the waiver of the applicable COBRA **Premium** or other continuation **Premium**.

2. The subsection entitled "Continuation Coverage Under North Carolina Law" located in the Continuation and Conversion section is hereby enlarged to include the following:

3. A **Member** who would otherwise lose coverage due to termination of active employment or membership, or termination of membership in the eligible class or classes under the policy, may continue uninterrupted coverage under this **Certificate** for up to sixty (60) days if the **Member** resides in the **HMO Service Area** and has been continuously covered under this **Certificate** or under a similar group benefit plan which this **Certificate** replaced, during the period of three consecutive months immediately prior to the date of termination. The employee or member shall make the first contribution upon the election to continue coverage, and the coverage shall be retroactive to the date of termination.

AETNA HEALTH INC.
(NORTH CAROLINA)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Definitions section of the **Certificate** is hereby amended. The definition of Behavioral Health Provider is deleted and replaced with the following:

- **Behavioral Health Provider.** A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions. This includes duly certified substance abuse professionals, who are certified by the North Carolina Substance Abuse Professional Certification Board.

AETNA HEALTH INC.
(NORTH CAROLINA)

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

Contract Holder Group Agreement Effective Date: January 1, 2013

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

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

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

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

   Coverage will not be terminated on the basis of a **Member's** health status or health care needs, nor if a **Member** has exercised the **Member's** rights under the **Certificate's** Complaints and Appeals, **External Review**, and Dispute Resolution sections to register a **Complaint** with **HMO**. The **Complaint** process described in the preceding paragraph applies only to those terminations affected pursuant to the Termination for Cause subsection of the **Certificate**.

   HMO shall provide the certification (i) at the time a **Member** ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision, (ii) in the case of a **Member** becoming covered under a COBRA continuation provision, at the time the **Member** ceases to be covered under the COBRA continuation provision, and (iii) on the request on behalf of a **Member** made not later than 24 months after the date of cessation of the coverage described in (i) or (ii), whichever is later.

   The certification under clause (i) may be provided to the extent practicable at a time consistent with notice required under any applicable COBRA continuation provision.

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

CLAIM PROCEDURES

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

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

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

- Your eligibility for coverage.
- Coverage determinations, including plan limitations or exclusions.
- .• The results of any Utilization Review activities.
- A decision that the service or supply is an **Experimental or Investigational Procedure**.
- A decision that the service or supply is not **Medically Necessary**.

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

HMO Timeframe for Notification of a Benefit Determination

Type of Claim	Response Time from Receipt of Claim
Urgent Care Claim. A claim for medical care or treatment where delay could seriously jeopardize the life or health of the **Member,** the ability of the **Member** to regain maximum function; or subject the **Member** to severe pain that cannot be adequately managed without the requested care or treatment.	As soon as possible, but not later than 72 hours after the claim is made. If more information is needed to make an **Urgent Care Claim** decision, **HMO** will notify the claimant within 72 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide **HMO** with the additional information. **HMO** will notify the claimant within 48 hours of the earlier to occur: • the receipt of the additional information; or • the end of the 48 hour period given the **Physician** to provide **HMO** with the information.
Pre-Service Claim. A claim for a benefit that requires pre-authorization of the benefit in advance of obtaining medical care.	Within 15 calendar days. **HMO** may determine that due to matters beyond its control an extension of this 15-calendar day claim decision period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if **HMO** notifies the **Member** within the first 15 calendar day period. If this extension is needed because **HMO** needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. The **Member** will have 45 calendar days, from the date of the notice, to provide **HMO** with the required information.
Concurrent Care Claim Extension. A request to extend a course of treatment previously pre-authorized by **HMO**.	If an urgent care claim as soon as possible, but not later than 24 hours provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. A decision will be provided not later than 15 calendar days with respect to all other care, following a request for a **Concurrent Care Claim Extension**.
Concurrent Care Claim Reduction or Termination.	With enough advance notice to allow the

Decision to reduce or terminate a course of treatment previously pre-authorized by **HMO**.	**Member** to **Appeal**. If the **Member** files an **Appeal**, **Covered Benefits** under the **Certificate** will continue for the previously approved course of treatment until a final **Appeal** decision is rendered. During this continuation period, the **Member** is responsible for any **Copayments** that apply to the services, supplies and treatment that are rendered in connection with the claim that is under **Appeal**. If **HMO's** initial claim decision is upheld in the final **Appeal** decision, the **Member** will be responsible for all charges incurred for services, supplies and treatment received during this continuation period.
Post-Service Claim. A claim for a benefit that is not a pre-service claim.	Within 30 calendar days. **HMO** may determine that due to matters beyond its control an extension of this 30-calendar day claim decision period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if **HMO** notifies the **Member** within the first 30 calendar day period. If this extension is needed because **HMO** needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. The **Member** will have 45 calendar days, from the date of the notice, to provide **HMO** with the required information.

COMPLAINTS AND APPEALS

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

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

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

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

A. **Complaints**.

If the **Member** is dissatisfied with the administrative services the **Member** receives from the **HMO** or wants to complain about a **Participating Provider,** call or write Member Services. The **Member** will need to include a detailed description of the matter and include copies of any records or documents that the **Member** thinks are relevant to the matter. The **HMO** will review the information and provide the **Member** with a written response within 30 calendar days of the receipt of the **Complaint**, unless additional information is needed and it cannot be obtained within this time frame. The response will tell the **Member** what the **Member** needs to do to seek an additional review.

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

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

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

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

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

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

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

The **HMO** provides for two level(s) of **Appeal** of the **adverse benefit determination**. The **Member** must complete all steps in the **HMO Appeals** process before bringing a lawsuit against the **HMO**. A **final adverse benefit determination** notice may provide an option to request an **External Review** *(if available)*. If the **Member** decides to **Appeal** to the second level, the request must be made in writing within 60 calendar days from the date of the notice. The following chart summarizes some information about how the **Appeals** are handled for different types of claims.

HMO Timeframe for Responding to an Adverse Benefit Determination Appeal

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

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

D. **Exhaustion of Process.**

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

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

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

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

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

Important Note:

If **HMO** does not adhere to all claim determination and **Appeal** requirements of the Federal Department of Health and Human Services, the **Member** is considered to have exhausted the **Appeal** requirements and may proceed with **External Review** or any of the actions mentioned above. There are limits, though, on what sends a claim or an **appeal** straight to an **External Review**. A **Member's** claim or internal **Appeal** *will not* go straight to **External Review** if:

- a rule violation was minor and isn't likely to influence a decision or harm the **Member**;
- it was for a good cause or was beyond **HMO's** control; and
- it was part of an ongoing, good faith exchange between the **Member** and **HMO**.

E. **Record Retention.**

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

F. **Fees and Costs.**

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

EXTERNAL REVIEW

North Carolina law provides for review of noncertification decisions by an external, independent review organization (IRO). The North Carolina Department of Insurance (NVDOI) administers this service at no charge to the **Member**, arranging for an IRO to review the **Member's** case once the NCDOI establishes that the Member's request is complete and eligible for review. The **Member** or someone the **Member** has authorized to represent them may request an external review. The **HMO** will notify the **Member** in writing of the **Member**'s right to request an external review each time the Member:

- receive a noncertification decision, or
- receive an appeal decision upholding a noncertification decision, or
- receive a second-level grievance review decision upholding the original noncertification.

In order for the **Member's** request to be eligible for external review, the NCDOI must determine the following:

- that the **Member's** request is about a medical necessity determination that resulted in a noncertification decision;
- that the **Member** had coverage with the **HMO** in effect when the noncertification decision was issued;
- that the service for which the noncertification was issued appears to be a covered service under the **Member's** policy; and
- that the **Member** has exhausted the **HMO's** internal review process as described below.

External review is performed on a **standard** and expedited timetable, depending on which is requested and on whether medical circumstances meet the criteria for expedited review.

For a **standard** external review, the **Member** will be considered to have exhausted the internal review process if the **Member** has:

- completed the **HMO**'s appeal and second level grievance processes and received a written second level determination from the **HMO**, or
- filed a second level grievance and except to the extent that the **Member** has requested or agreed to a delay, has not received the **HMO**'s written decision within 60 days of the date the **Member** submitted the request, or
- received notification that the **HMO** has agreed to waive the requirement to exhaust the internal appeal and/or second level grievance process.

If the **Member's** request for a **standard** external review is related to a retrospective noncertification (a noncertification which occurs after the **Member** has received the services in question), the **Member** will not be eligible to request a standard review until the **Member** has completed the **HMO**'s internal review process and received a written final determination from the **HMO**.

If the **Member** wishes to request a **standard** external review, the **Member** (or the **Member's** representative) must make this request to NCDOI within 120 days of receiving the **HMO**'s written notice of final determination that the services in question are not approved. When processing the **Member's** request for external review, the NCDOI will require the **Member** to provide the NCDOI with a written, signed authorization for the release of any of the Member's medical records that may need to be reviewed for the purpose of reaching a decision on the external review.

Within 10 business days of receipt of the **Member's** request for a standard external review, the NCDOI will notify the **Member** and the **Member's** provider of whether the **Member's** request is complete and whether it is accepted. If the NCDOI notifies the **Member** that the **Member's** request is incomplete, the **Member** must provide all requested additional information to the NCDOI within 90 days of the date of the **HMO**'s written notice of final determination. If the NCDOI accepts the **Member's** request, the acceptance notice will include:

- the name and contact information for the **Independent Review Organization** (IRO) assigned to the **Member's** case;
- a copy of the information about the **Member's** case that the **HMO** has provided to the NCDOI; and
- notification that the **Member** may submit additional written information and supporting documentation relevant to the initial noncertification to the assigned IRO within 7 days of the date of the acceptance notice.

If the **Member** chooses to provide any additional information to the IRO, the **Member** must also provide that same information to the **HMO** at the same time using the same means of communication (e.g., the **Member** must fax the information to the **HMO** if the **Member** faxed it to the IRO). When faxing information to the **HMO**, send it to 678-256-0366. If the **Member** choose to mail the **Member's** information, send it to:

AETNA HEALTH INC.
National External Review Unit
11675 Great Oaks Way
Alpharetta, GA 30022

Please note that the **Member** may also provide this additional information to the NCDOI within the 7-day deadline rather than sending it directly to the IRO and the **HMO**. The NCDOI will forward this information to the IRO and the **HMO** within two business days of receiving the **Member's** additional information.

The IRO will send the **Member** written notice of its determination within 45 days of the date the NCDOI received the **Member's** standard external review request. If the IRO's decision is to reverse the noncertification, the **HMO** will, reverse the noncertification decision within 3 business days of receiving notice of the IRO's decision, and provide coverage for the requested service or supply that was the subject of the noncertification decision. If the **Member** is no longer covered by the **HMO** at the time the **HMO** receives notice of the IRO's decision to reverse the noncertification, the **HMO** will only provide coverage for those services or supplies the **Member** actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

An **expedited** external review of a noncertification decision may be available if the **Member** has a medical condition where the time required to complete either an **expedited** internal appeal or a second level grievance review or a **standard** external review would reasonably be expected to seriously jeopardize the **Member's** life or health or would jeopardize the **Member's** ability to regain maximum function. If the **Member** meets this requirement, the **Member** may make a written or verbal request to the NCDOI for an **expedited** review after the **Member**:

- receives a noncertification decision from the **HMO** AND files a request with the **HMO** for an **expedited** appeal, or
- receives an appeal decision upholding a noncertification decision AND files a request with the **HMO** for an **expedited** second level grievance review, or
- receives a second level grievance review decision upholding the original noncertification.

The **Member** may also make a request for an **expedited** external review if the **Member** receives an adverse second level grievance review decision concerning a noncertification of an admission, availability of care, continued stay or emergency care, but have not been discharged from the inpatient facility.

In consultation with a medical professional, the NCDOI will review the **Member's** request and determine whether it qualifies for **expedited** review. The **Member** and the **Member's** provider will be notified within 3 business days if the **Member's** request is accepted for **expedited** external review. If the **Member's** request is not accepted for **expedited** review, the NCDOI may: (1) accept the case for **standard** external review if the **HMO**'s internal review process was already completed, or (2) require the completion of the **HMO**'s internal review process before the **Member** may make another request for an external review with the NCDOI. An **expedited** external review is not available for retrospective noncertifications.

The IRO will communicate its decision to the **Member** within 4 business days of the date the NCDOI received the Member's request for an **expedited** external review. If the IRO's decision is to reverse the noncertification, the **HMO** will, within one day of receiving notice of the IRO's decision, reverse the noncertification decision for the requested service or supply that is the subject of the noncertification decision. If the **Member** is no longer covered by the **HMO** at the time the **HMO** receives notice of the IRO's decision to reverse the noncertification, the **HMO** will only provide coverage for those services or supplies the **Member** actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

For further information about **External** Review or to request an external review, contact the NCDOI at:

By Mail:

NC Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
(fax) 919-807-6865

In Person

Dobbs Building
430 N. Salisbury St.
1th Floor, Suite 1018
Raleigh, NC
1-877-885-0231 (Toll Free)
1-919-807-6860
www.ncdoi.com/Smart for External Review Information and Request Form

The Health Insurance Smart NC is available to assist Consumers with filing appeals and grievances to their health plan.

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

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

AETNA HEALTH INC.
(NORTH CAROLINA)

CERTFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Conversion Privilege provision within the Continuation and Conversion section of the **Certificate** is hereby amended to add the following:

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

AETNA HEALTH INC.
(NORTH CAROLINA)

COORDINATION OF BENEFITS AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The definitions of **Allowable Expense** and **Coordination of Benefits** shown in the Definitions section of the **Certificate** are hereby deleted.

The **Coordination of Benefits** section of the **Certificate** is deleted in its entirety and is replaced with the following:

COORDINATION OF BENEFITS

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

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

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

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

3. If a **Member** is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable Expense**, unless the **Secondary Plan's** provider's contract prohibits any billing in excess of the provider's agreed upon rates.

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

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

Claim Determination Period(s). Usually the calendar year.

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

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

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

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

1. Group, health insurance policies issued by insurers, including health care service contractors. This does not include school accident-type, blanket or franchise coverage;
2. Other prepaid coverage under service plan contracts, or under group or individual practice;
3. Uninsured arrangements of group or group-type coverage;
4. Labor-management trusteed plans, labor organization plans, employer organization plans, or employee benefit organization plans;
5. Medicare or other governmental benefits. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended). It does not include any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.
6. Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

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

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

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

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

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

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

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

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

Order of Benefit Determination.

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

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

B. **Plan** that does not contain a **COB** provision that is consistent with this provision is always primary.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Effect on Benefits of this Certificate.

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

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

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

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

Effect of Medicare on COB.

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

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

1. Are covered under a program;

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

3. Have terminated coverage under a program; or

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

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

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

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

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

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

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

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

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

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

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

Multiple Coverage Under This Plan.

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

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

Right to Receive and Release Needed Information.

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits under this **Plan** and other **Plans**. **HMO** has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility of Payment.

Any payment made under another **Plan** may include an amount which should have been paid under coverage under this **Certificate**. If so, **HMO** may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under this **Certificate**. **HMO**

will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery.

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

AETNA HEALTH INC.
(NORTH CAROLINA)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Diagnostic Services section of the **Certificate** is hereby expanded to include the following provision:

Ovarian Cancer Surveillance tests for women 25 years of age and older are provided when:

1. The woman is at risk for ovarian cancer and has a family history:

    a. With at least one first-degree relative with ovarian cancer;
    b. A second relative, either first degree or second degree, with breast, ovarian or nonpolyposis colorectal cancer; or
    c. Testing positive for a hereditary ovarian cancer syndrome.

2. "Surveillance Tests" mean annual screening using:

    a. Transvaginal ultrasound; and
    b. Rectovaginal pelvic examination.

AETNA HEALTH INC.
(NORTH CAROLINA)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

- **Self-injectable Drug(s)**. Prescription drugs that are intended to be self administered by injection to a specific part of the body to treat certain chronic medical conditions. An updated copy of the list of **Self-injectable Drugs** that are not **Covered Benefits** shall be available upon request by the **Member** or may be accessed at the **HMO** website, at www.aetna.com. The list is subject to change by **HMO** or an affiliate.

The Injectable Medications Benefits in the Covered Benefits section of the **Certificate** is hereby deleted and replaced with the following:

- **Injectable Medications Benefits.**

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

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

AETNA HEALTH INC.
(NORTH CAROLINA)

HOME HEALTH CARE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

The Definitions of **"Custodial Care"**, **"Homebound Member"**, **"Skilled Care"** and **"Skilled Nursing Facility"** are hereby deleted and replaced with the following definitions:

- **Custodial Care.** Services and supplies that are primarily intended to help a **Member** meet their personal needs. Care can be **Custodial Care** even if it is prescribed by a **Physician**, delivered by trained medical personnel, or even if it involves artificial methods (or equipment) such as feeding tubes, monitors, or catheters. Examples of **Custodial Care** include, but are not limited to:

  1. Changing dressings and bandages, periodic turning and positioning in bed, administering oral medication, watching or protecting a **Member**.
  2. Care of a stable tracheostomy, including intermittent suctioning.
  3. Care of a stable colostomy/ileostomy.
  4. Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings.
  5. Care of a stable indwelling bladder catheter, including emptying/changing containers and clamping tubing.
  6. Respite care, adult (or child) day care, or convalescent care.
  7. Helping a **Member** perform an activity of daily living, such as: walking, grooming, bathing, dressing, getting in and out of bed, toileting, eating, or preparing food.
  8. Any services that an individual without medical or paramedical training can perform or be trained to perform.

- **Homebound Member.** A **Member** who is confined to their place of residence due to an illness or injury which makes leaving the home medically contraindicated or if the act of transport would be a serious risk to their life or health.

  Examples where a **Member** would not be considered homebound are:

  1. A **Member** who does not often travel from home because of feebleness and/or insecurity brought on by advanced age (or otherwise).

  2. A wheelchair bound **Member** who could safely be transported via wheelchair accessible transport.

- **Skilled Nursing.** Services that require the medical training of and are provided by a licensed nursing professional and are not **Custodial Care**.

- **Skilled Nursing Facility.** An institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing **Skilled Nursing** care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. **Skilled Nursing Facility** does not include institutions which provide only minimal care, **Custodial Care** services, ambulatory or part-time care services, or institutions which primarily provide for the care and treatment of mental illness and substance abuse. The facility must qualify as a **Skilled Nursing Facility** under Medicare or as an institution accredited by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association, the Commission on the Accreditation of Rehabilitative Facilities, or as otherwise

determined by the health insurer to meet the reasonable standards applied by any of the aforesaid authorities. Examples of **Skilled Nursing Facilities** include Rehabilitation Hospitals (all levels of care, e.g. acute) and portions of a **Hospital** designated for Skilled or Rehabilitation services.

The **Home Health Benefits** provision under the Covered Benefits section of the **Certificate** is hereby deleted and replaced with the following:

Home Health Benefits.

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

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

Services of a home health aide are covered only when they are provided in conjunction with **Skilled Nursing** services and directly support the **Skilled Nursing**. Services must be provided during intermittent visits of 4 hours or less with a daily maximum of 3 visits. Services are subject to the limits, if any, listed in the Outpatient Home Health Visits section of the Schedule of Benefits.

Medical social services are covered only when they are provided in conjunction with **Skilled Nursing** services and must be provided by a qualified social worker.

Outpatient home health short-term physical, speech, or occupational therapy is covered when the above home health care criteria are met. Coverage is subject to the conditions and limits listed in the Outpatient Rehabilitation Benefit section of the **Certificate** and the Outpatient Rehabilitation section of the Schedule of Benefits.

The Private Duty Nursing exclusion under the Exclusions and Limitations section of the **Certificate** is hereby deleted and replaced with the following:

- Private Duty Nursing *(See the Home Health Benefits section regarding coverage of nursing services)*.

The Exclusions and Limitations section of the **Certificate** is hereby amended to include the following:

- Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).

AETNA HEALTH INC.
(NORTH CAROLINA)

HIPAA SPECIAL ENROLLMENT/PREEXISTING/PORTABILITY AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

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

6. Special Enrollment Period.

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

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

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

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

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

c. the eligible individual or eligible dependent loses coverage under the other group health plan or other health insurance coverage for 1 of the following reasons:

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

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

Loss of eligibility includes the following:

- a loss of coverage as a result of legal separation, divorce or death;
- termination of employment;
- reduction in the number of hours of employment;
- any loss of eligibility after a period that is measured by reference to any of the foregoing;
- termination of **HMO** coverage due to **Member** action- movement outside of the **HMO**'s service area; and also the termination of health coverage including Non-**HMO**, due to plan termination;

- plan ceases to offer coverage to a group of similarly situated individuals;
- cessation of a dependent's status as an eligible dependent;
- termination of benefit package.

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

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

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

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

Special Enrollment Period When a New Eligible Dependent is Acquired:

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

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

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

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

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

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

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

  A late enrollee is an individual who enrolls in **HMO** at a time other than: the first time the individual is eligible to enroll, during any **Open Enrollment Period**, or during a special enrollment period.

  HMO waives this preexisting condition limitation provision if, under a prior group or individual health benefits plan, there has been a significant break in coverage for not more than a -90 consecutive day period,

except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. The preexisting condition limitation period will be reduced by the number of days of prior **Creditable Coverage** the **Member** has as of the **Effective Date of Coverage** under this **Certificate**.

AETNA HEALTH INC.
(NORTH CAROLINA)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

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

Residential Treatment Facility – (Mental Disorders)

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

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

Residential Treatment Facility – (Alcoholism and Drug Abuse)

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

- On-site licensed **Behavioral Health Provider** 24 hours per day/7 days a week
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a **Physician.**
- Has access to necessary medical services 24 hours per day/7 days a week.
- If the member requires detoxification services, must have the availability of on-site medical treatment 24 hours per day/7days a week, which must be actively supervised by an attending **Physician**.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.

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

AETNA HEALTH INC.
(NORTH CAROLINA)

DISCOUNT PROGRAMS CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. **Certificate** is hereby amended to add the following provisions to the General Provisions section of the **Certificate**

Q. **Additional Provisions**:

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

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

AETNA HEALTH INC.
(NORTH CAROLINA)

GENERAL PROVISIONS AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

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

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

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

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

AETNA HEALTH INC.
(NORTH CAROLINA)

WORKERS' COMPENSATION AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

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

RECOVERY RIGHTS RELATED TO WORKERS' COMPENSATION

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

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

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

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

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

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

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

a) the employer or carrier is found liable or responsible according to a final adjudication of the claim under the Workers' Compensation Act, Article 1 of Chapter 97 of the General Statutes; or

b) an order of the North Carolina Industrial Commission approving a settlement agreement is entered; or

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

AETNA HEALTH INC.
NORTH CAROLINA

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

Contract Holder Group Agreement Effective Date: January 1, 2013

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

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

Continuation Coverage for Dependent Students on Medical Leave of Absence

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

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

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

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

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

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

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

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

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

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

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

If:

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

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

3. this plan provides coverage for eligible dependents;

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

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

AETNA HEALTH INC.
(NORTH CAROLINA)

COMPASSIONATE CARE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

1. The **Hospice Care** definition in the Definitions section of the **Certificate** is deleted and replaced with the following:

   - **Hospice Care**. A program of care that is provided by a **Hospital**, **Skilled Nursing Facility**, hospice, or a duly licensed Hospice Care agency, and is approved by **HMO**, and is focused on a palliative rather than curative treatment for **Members** who have a medical condition and a prognosis of less than 12 months to live.

AETNA HEALTH INC.
(NORTH CAROLINA)

CERTIFICATE OF COVERAGE AMENDMENT

HEARING AID BENEFIT

Contract Holder Group Agreement Effective Date:January 1, 2013

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

1. The following benefits are added to the Covered Benefits section of the **Certificate**:

   Coverage of Hearing Aids

   Services include charges made for one hearing aid per hearing-impaired ear for covered persons under age 22. The coverage must be ordered by a **Participating Provider** or a licensed audiologist.

   Services shall include:
   - An initial or one replacement hearing aid not more frequently than once every 36 months;
   - A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the covered person;
   - The initial hearing aid evaluation, fittings, and adjustments, and supplies, including ear molds.

   Benefits shall be subject to the same **deductibles, coinsurance** or **copayments and limitations**, if applicable, used for other similar **covered expenses**.

   The maximum benefit payable is limited to $2,500 per hearing aid for each hearing-impaired ear every
   36 months.

2. The Hearing Aid exclusion under the Exclusions and Limitations section of the **Certificate** is hereby deleted and replaced with the following:

   - Hearing Aids except for one hearing aid per hearing-impaired ear for covered persons under age 22.

3. The Aetna Health Inc. **Schedule of Benefits** is hereby amended as follows:

   The following is added to the Schedule of Benefits:

   Hearing Aids (for person under age 22)

Hearing Aid Benefit Maximum	$2,500 per hearing aid for each hearing-impaired ear every 36 months.

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

AETNA HEALTH INC.
(NORTH CAROLINA)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

HMO. Aetna Health Inc., a Pennsylvania corporation licensed by the North Carolina Department of Insurance as a **Health Maintenance Organization.**

This Amendment shall be attached to and become part of the Plan Documents and is subject to all terms, conditions and limitations of the Plan Documents.

AETNA HEALTH INC.
(NORTH CAROLINA)

CERTIFICATE OF COVERAGE AND
SCHEDULE OF BENEFITS
AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

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

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

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

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

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

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

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

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

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

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

  - Diagnostic X-Ray and Laboratory Testing;

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

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

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

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

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

AETNA HEALTH INC.
(NORTH CAROLINA)

HIPAA/CHIPRA SPECIAL ENROLLMENT AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. **Certificate**, and/or any applicable amendment to the **Certificate** is hereby amended as follows:

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

6. Special Enrollment Period.

An eligible individual and eligible dependents may be enrolled during a Special Enrollment Periods. A Special Enrollment Period may apply when an eligible individual or eligible dependent loses other health coverage or when an eligible individual acquires a new eligible dependent through marriage, birth, adoption or placement for adoption.

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

An eligible individual or an eligible dependent may be enrolled during a Special Enrollment Period, if the following requirements, as applicable, are met:

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

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

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

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

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

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

iii. the other health insurance coverage is Medicaid or an S-Chip plan and the eligible individual or eligible dependent no longer qualifies for such coverage.

Loss of eligibility includes the following:

- a loss of coverage as a result of legal separation, divorce or death;
- termination of employment;
- reduction in the number of hours of employment;
- any loss of eligibility after a period that is measured by reference to any of the foregoing;
- termination of **HMO** coverage due to **Member** action- movement outside of the **HMO**'s service area; and also the termination of health coverage including Non-**HMO**, due to plan termination.

- plan ceases to offer coverage to a group of similarly situated individuals;
- cessation of a dependent's status as an eligible dependent
- termination of benefit package

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

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

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

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

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

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

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

Special Enrollment Period When a New Eligible Dependent is Acquired:

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

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

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

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

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

AETNA HEALTH INC.
(NORTH CAROLINA)

ENROLLMENT ENDORSEMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

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

ELIGIBILITY AND ENROLLMENT

The Eligibility and Enrollment section of the **Certificate** is amended to include the following:

Employees will be permitted to enroll in **HMO** at any time during the year provided the circumstances surrounding the enrollment involve a "Life Event" occurrence and the enrollment form is received by **HMO** within 31 days of when the event occurs.

"Life Events" are limited to:

- a marriage or divorce of the employee;
- the death of the employee's spouse or a dependent;
- the birth, proposed adoption or adoption of a child of the employee or placement of a foster child with an employee;
- the termination or commencement of employment of the employee's spouse;
- the switching from part-time to full-time employment status or from full-time to part-time status by the employee or employee's spouse;
- the taking of an unpaid leave of absence of the employee or employee's spouse;
- a significant change in health coverage of employee or spouse attributable to spouse's employment.

AETNA HEALTH INC.
(NORTH CAROLINA)

HMO AETNA HEALTH INC. OPEN ACCESS™ RIDER

Contract Holder Group Agreement Effective Date: January 1, 2013

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

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

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

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

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

The **PCP** provides services for the treatment of routine illnesses, injuries, well baby and preventive care services which do not require the services of a **Specialist**, and for non-office hour **Urgent Care** services under this plan. The **Member's** selected **PCP** or that **PCP's** covering **Physician** is required to be available 7 days a week, 24 hours a day for **Urgent Care** services.

A **Member** is encouraged to select a **PCP** for themselves and for each of their **Covered Dependents** at the time of enrollment, however this is not a plan requirement. If a **Member** selects a **PCP**, the **Member** may change their **PCP** at any time by contacting **HMO**.

A **Member** will be subject to the **PCP Copayment** listed on the Schedule of Benefits when a **Member** obtains **Covered Benefits** from any **Participating PCP**.

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

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

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

- **Self-Referred Services**.

Except as described in the Exclusions and Limitations section of this Rider, the **Certificate**, any amendments and/or riders are hereby revised to remove the requirement that a **Member** must obtain a **Referral** from their **PCP** prior to accessing **Covered Benefits** from **Participating Providers**.

Under this provision, a **Member** may directly access **Participating Specialists**, ancillary **Providers** and facilities for **Covered Benefits** without a **PCP Referral**, subject to the terms and conditions of the **Certificate** and any cost-sharing requirements set forth in the Schedule of Benefits. **Participating Providers** will be responsible for obtaining pre-authorization of services from **HMO**.

Except as described in this Rider, the **Covered Benefits** section and the Exclusions and Limitations section of the **Certificate** remain unchanged and the ability of a **Member** to directly access **Participating Providers** does not alter any other provisions of the **Certificate**. Except for **Emergency Services** and out-of-area **Urgent Care** services, a **Member** must access **Covered Benefits** from **Participating Providers** and facilities or benefits will not be covered under this **Certificate** and a **Member** will be responsible for all expenses incurred unless **HMO** has pre-authorized the services to a non-participating **Provider**.

The Exclusions and Limitations section of the **Certificate** is amended to delete the following exclusion:

- Unauthorized services, including any service obtained by or on behalf of a **Member** without a prior written **Referral** issued by the **Member's PCP** or certified by **HMO**. This exclusion does not apply in a **Medical Emergency** or in an **Urgent Care** situation or when it is a direct access benefit.

The Exclusions and Limitations section of the **Certificate** is amended to include the following exclusion:

- Unauthorized services obtained by the **Member** that require pre-authorization by **HMO** including but not limited to **Hospital** admissions and outpatient surgery. **Participating Providers** are responsible for obtaining pre-authorization of **Covered Benefits** from **HMO**.

- Upon pre-authorization, other treatment plans may be subject to case management and a **Member** may be directed to specific **Participating Providers** for **Covered Benefits** including, but not limited to transplants and other treatment plans.

- Supplemental plans provided under a separate contract or policy in addition to an **HMO** health benefit plan, including but not limited to dental plans and behavioral health plans, are not subject to the provisions of this Rider and a **Member** is required to abide by the terms and conditions of the separate contract or policy.

AETNA HEALTH INC.
(NORTH CAROLINA)

DOMESTIC PARTNER RIDER

Contract Holder Group Agreement Effective Date: January 1, 2013

The Domestic Partner rider for this contract is effective January 1, 2013
The Eligibility and Enrollment section of the **Certificate** is hereby deleted and replaced with the following:

a. the legal spouse or domestic partner of a **Subscriber** under this **Certificate**, and who, as of the date of enrollment (with respect to a domestic partner):

i. provides proof of cohabitation (e.g. driver's license or tax return);
ii. are both of the age of consent in their state of residence;
iii. are not related by blood in any manner that would bar marriage in their state of residence;
iv. have a close, committed and monogamous personal relationship;
v. have been sharing the same household on a continuous basis for at least 6 months;
vi. have registered as domestic partners where such registration is available;
vii. is not married to, or separated from, another individual;
viii. have not been registered as a member of another domestic partnership within the last 6 months; and
ix. demonstrates financial interdependence by submission of proof of three or more of the following:

a) common ownership of real property or a common leasehold interest in such property;
b) common ownership of a motor vehicle;
c) joint bank accounts or credit accounts;
d) designation as a beneficiary for life insurance or retirement benefits, or under the partner's will;
e) assignment of a durable power of attorney or health care power of attorney; or
f) such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case;

g) and is of the same sex as the **Subscriber**.

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

AETNA HEALTH INC.

PRESCRIPTION LENS RIDER

Contract Holder Group Agreement Effective Date: January 1, 2013

Aetna Health of the Carolinas Inc. ("**HMO**") and **Contract Holder** agree to offer to **Members** the **HMO** Prescription Lens plan, subject to the following provisions:

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

- **Prescription Lens Benefits.**

  Member is eligible for an allowance up to $100 for the purchase of prescription lenses and frames (including prescription contact lenses). This allowance is payable once in each 24 month period commencing with the date of **Member's** initial use of this benefit.

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

The Continuation and Conversion section of the **Certificate** is hereby amended to add the following provision:

The conversion privilege does not apply to the Prescription Lens Rider.

AETNA HEALTH INC.
NORTH CAROLINA

MORBID OBESITY SURGICAL TREATMENT RIDER

Contract Holder Group Agreement Effective Date: January 1, 2013

Aetna Health Inc., ("**HMO**") and **Contract Holder**, agree to provide to **Members** the Morbid Obesity Surgical Treatment Rider subject to the following provisions:

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

- **Body Mass Index.** A practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

- **Morbid Obesity. A Body Mass Index** that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a high risk comorbid medical condition, including significant cardiovascular disease, sleep apnea, or uncontrolled type-2 diabetes.

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

- **Morbid Obesity Surgical Benefits**

  Surgical treatment of **Morbid Obesity** is a **Covered Benefit**, when provided by a **Participating Provider** and when authorized in advance by **HMO**. Coverage includes one surgical procedure within a two-year period, beginning with the date of the first **Morbid Obesity** surgical procedure, unless a multi-stage procedure is planned and approved by **HMO**.

  Coverage for Morbid Obesity Surgical benefits are only provided for referred care.

  Refer to the Schedule of Benefits attached to this **Certificate** for applicable cost sharing provisions.

The following exclusions are hereby deleted from the Exclusions and Limitations section of the **Certificate**:

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

- Weight reduction programs, or dietary supplements.

The Exclusions and Limitations section of the **Certificate** is hereby amended to add the following exclusion(s):

- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including **Morbid Obesity**, or for the purpose of weight reduction**,** regardless of the existence of comorbid conditions; except as provided by this rider.

The Continuation and Conversion section of the **Certificate** is hereby amended to add the following provision:

The conversion privilege, if any, does not apply to the Morbid Obesity Surgical Treatment Rider.

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

MORBID OBESITY SURGICAL TREATMENT BENEFITS

Benefit	Deductible/Copayment/Maximums
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services).	**Refer to the Schedule of Benefits for applicable cost sharing provisions.**

Copayment(s) for **Morbid Obesity** services do not apply to the Maximum Out-of-Pocket Copayment Limit, if any, listed in the Schedule of Benefits.

AETNA HEALTH INC.
(NORTH CAROLINA)

PRESCRIPTION PLAN RIDER

Group Agreement Effective Date: **January 1, 2013**

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

DEFINITIONS

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

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

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

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

- **Drug Formulary Exclusions List**. A list of prescription drugs excluded from the **Drug Formulary**, subject to change from time to time at the sole discretion of **HMO**.

- **Generic Prescription Drug(s)**. Prescription drugs and insulin, whether identified by their chemical, proprietary, or non-proprietary name, that are accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by MediSpan or any other similar publication designated by **HMO** or an affiliate.

- **Non-Formulary Prescription Drug(s).** A product or drug not listed on the **Drug Formulary** which includes drugs listed on the **Drug Formulary Exclusions List**.

- **Participating Mail Order Pharmacy.** A pharmacy, which has contracted with **HMO** or an affiliate to provide covered outpatient prescription drugs or medicines, and insulin to **Members** by mail or other carrier.

- **Participating Retail Pharmacy**. A community pharmacy which has contracted with **HMO** or an affiliate to provide covered outpatient prescription drugs to **Members**.

- **Precertification Program (Restricted Drugs and Devices).** For certain outpatient prescription drugs, prescribing **Physicians** must contact **HMO** or an affiliate to request and obtain coverage for such drugs. The list of drugs requiring precertification is subject to change by **HMO** or an affiliate. An updated copy of the list of drugs requiring precertification shall be available upon request by the **Member** or may be accessed at the pharmacy website, at www.aetna.com.

- **Restricted Drugs and Devices.** Those covered prescription drugs or devices for which reimbursement by the **HMO** is conditioned on the **HMO's** prior approval to prescribe the drug or device or on the **Participating Physician** prescribing one or more alternative drugs or devices before prescribing the drug or device in question.

  Coverage for **Restricted Drugs and Devices** will be provided to the **Member** without requiring prior approval or use of a non-restricted formulary drug if the **Member's Participating Physician** certifies in writing that the **Member** has previously used an alternative non-restricted drug or device and the alternative drug or device has been detrimental to the **Member's** health or has been ineffective in treating the same condition and, in the opinion of the **Participating Physician**, is likely to be detrimental to the **Member's** health or ineffective in treating the condition again.

- **Step Therapy Program (Restricted Drugs and Devices).** A form of precertification under which certain prescription drugs will be excluded from coverage**,** unless a first-line therapy drug(s) is used first by the **Member**. The list of step therapy drugs is subject to change by **HMO** or an affiliate. An updated copy of the list of drugs subject to step therapy shall be available upon request by the **Member** or may be accessed at the pharmacy website, at www.aetna.com.

- **Therapeutic Drug Class.** A group of drugs or medications that have a similar or identical mode of action or exhibit similar or identical outcomes for the treatment of a disease or injury.

COVERED BENEFITS

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

A. **Outpatient Prescription Drug Open Formulary Benefit**

Medically Necessary outpatient prescription drugs and insulin are covered when prescribed by a **Provider** licensed to prescribe federal legend prescription drugs or medicines subject to the terms, **HMO** policies, Exclusions and Limitations section described in this rider and the **Certificate**. Coverage is based on **HMO's** or an affiliate's determination, in its sole discretion, if a prescription drug is covered. Some items are covered only with pre-authorization from **HMO**. Items covered by this rider are subject to drug utilization review by **HMO** and/or **Member's Participating Provider** and/or **Member's Participating Retail** or **Mail Order Pharmacy**.

B. Each prescription is limited to a maximum 30 day supply when filled at a **Participating Retail Pharmacy** or 90 day supply when filled by the **Participating Mail Order Pharmacy** designated by **HMO.** Except in an emergency or **Urgent Care** situation, or when the **Member** is traveling outside the **HMO Service Area**, prescriptions must be filled at a **Participating Retail** or **Mail Order Pharmacy**. Coverage of prescription drugs may, in **HMO's** sole discretion, be subject to the **Precertification Program (Restricted Drugs and Devices)**, the **Step Therapy Program (Restricted Drugs and Devices)** or other **HMO** requirements or limitations.

C. FDA approved prescription drugs are covered when the off-label use of the drug has not been approved by the FDA for that indication, provided that such drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information), or the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer reviewed journal. Coverage of off label use of these drugs may, in **HMO**'s sole discretion, be subject to the **Precertification Program (Restricted Drugs and Devices)**, the **Step Therapy Program (Restricted Drugs and Devices)** or other **HMO** requirements or limitations.

D. **Emergency Prescriptions -** Emergency prescriptions are covered subject to the following terms:

When a **Member** needs a prescription filled in an emergency or **Urgent Care** situation, or when the **Member** is traveling outside of the **HMO Service Area**, **HMO** will reimburse the **Member** as described below.

When a **Member** obtains an emergency or out-of-area **Urgent Care** prescription at a non-**Participating Retail Pharmacy**, **Member** must directly pay the pharmacy in full for the cost of the prescription. **Member** is responsible for submitting a request for reimbursement in writing to **HMO** with a receipt for the cost of the prescription. Reimbursement requests are subject to professional review by **HMO** to determine if the event meets **HMO's** requirements. Upon approval of the claim, **HMO** will directly reimburse the **Member** 100% of the cost of the prescription; the **HMO's Contracted Rate** with **Participating** pharmacy, less the applicable **Copayment** specified below and any **Brand Name Prescription Drug** cost differentials as applicable. Coverage for items obtained from a non-**Participating** pharmacy is limited to items obtained in connection with covered emergency and out-of-area **Urgent Care** services. **Members** must access a **Participating Retail Pharmacy** for **Urgent Care** prescriptions inside the **HMO Service Area**.

When a **Member** obtains an emergency or **Urgent Care** prescription at any **Participating Retail Pharmacy**, including an out-of-area **Participating Retail Pharmacy**, **Member** will pay to the **Participating Retail Pharmacy** the **Copayment(s),** plus the **Brand Name Prescription Drug** cost differentials where applicable and as described below. **Members** are required to present their ID card at the time the prescription is filled. **HMO** will review and approve claims for direct reimbursement to a **Member** for a prescription purchased at a **Participating Retail Pharmacy** on a case-by-case basis. **Members** must access a **Participating Retail Pharmacy** for **Urgent Care** prescriptions inside the **HMO Service Area**

E. **Mail Order Prescription Drugs.** Subject to the terms and limitations set forth in this rider, **Medically Necessary** outpatient prescription drugs are covered when dispensed by the **Participating Mail Order Pharmacy** designated by **HMO** and when prescribed by a **Participating Provider** licensed to prescribe federal legend prescription drugs. Outpatient prescription drugs will not be covered if dispensed by a **Participating Mail Order Pharmacy** in quantities that are more than a 90 day supply (if the **Provider** prescribes such amounts).

F. **Additional Benefits.**

The following prescription drugs, medicines, and supplies are also covered subject to the terms described in this rider:

- **Diabetic Supplies.**

  The following diabetic supplies are covered if **Medically Necessary** upon prescription or upon **Physician's** order only at a **Participating Retail** or **Mail Order Pharmacy**. The **Member** must pay applicable **Copayments** as described in the Copayments section below.

  1. Diabetic needles/syringes.
  2. Test strips for glucose monitoring and/or visual reading.
  3. Diabetic test agents.
  4. Lancets/lancing devices.
  5. Alcohol swabs.

- **Contraceptives.**

The following contraceptives and contraceptive devices are covered upon prescription or upon the **Participating Physician's** order only at a **Participating Retail** or **Mail Order Pharmacy**:

1. Oral Contraceptives.
2. Diaphragms, 1 per 365 consecutive day period**.**
3. Injectable contraceptives, the prescription plan **Copayment** applies for each vial up to a maximum of 5 vials per calendar year.
4. Contraceptive patches
5. Contraceptive rings
6. Norplant and IUDs are covered when obtained from a **Participating Physician.** The **Participating Physician** will provide insertion and removal of the device. An office visit **Copayment** will apply, if any. A **Copayment** for the contraceptive device may also apply.

- **Lifestyle/Performance Drugs**. Sildenafil Citrate, phentolamine, apomorphine and alprostadil in oral, injectable and topical (including but not limited to gels, creams, ointments and patches) forms or any other form used internally or externally are covered for **Members**. Coverage includes any prescription drug in oral or topical form that is in a similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes.

  Coverage is limited to 6 pills or other form, determined cumulatively among all forms, for unit amounts as determined by **HMO** to be similar in cost to oral forms, per 30-day supply. Mail order and 90-day supplies are not covered. The **Member** is responsible for a **Copayment** in the amount listed in this rider.

G. **Copayments:**

Member is responsible for the **Copayments** specified in this rider. The **Copayment,** if any, is payable directly to the **Participating Retail** or **Mail Order Pharmacy** for each prescription or refill at the time the prescription or refill is dispensed. If the **Member** obtains more than a 30 day supply of prescription drugs or medicines at the **Participating Mail Order Pharmacy**, not to exceed a 90 day supply, 2 **Copayments** are payable for each supply dispensed**.** The **Copayment** does not apply to the Maximum Out-of-Pocket Limit shown in the Schedule of Benefits for the medical plan, if any.

Prescription Drug/Medicine Quantity	**Generic Formulary Prescription Drugs**	**Brand Name Formulary Prescription Drugs**	**Non-Formulary Prescription Drugs**
Less than a 31 day supply	**$20**	**$40**	**$70**

EXCLUSIONS AND LIMITATIONS

The Exclusions and Limitation section of the **Certificate** is amended to include the following exclusions and limitations:

A. **Exclusions.**

Unless specifically covered under this rider, the following are not covered:

1. Any drug which does not, by federal or state law, require a prescription order (i.e., an over-the-counter (OTC) drug) or for which an equivalent over-the-counter product in

strength, is available even when a prescription is written, unless otherwise covered by **HMO**.

2. Any drug determined not to be **Medically Necessary** for the treatment of disease or injury unless otherwise covered under this rider.
3. Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by **HMO**.
4. Cosmetic or any drugs used for cosmetic purposes or to promote hair growth, including but not limited to health and beauty aids.
5. Needles and syringes, excluding diabetic needles and syringes.
6. Any medication which is consumed or administered at the place where it is dispensed, or while a **Member** is in a **Hospital**, or similar facility; or take home prescriptions dispensed from a **Hospital** pharmacy upon discharge, unless the pharmacy is a **Participating Retail Pharmacy**.
7. Immunization or immunological agents, including but not limited to, biological sera, blood, blood plasma or other blood products administered on an outpatient basis, allergy sera and testing materials.
8. Drugs used for the purpose of weight reduction (e.g., appetite suppressants), including the treatment of obesity.
9. Any refill in excess of the amount specified by the prescription order. Before recognizing charges, **HMO** may require a new prescription or evidence as to need, if a prescription or refill appears excessive under accepted medical practice standards.
10. Any refill dispensed more than 1 year from the date the latest prescription order was written, or as otherwise permitted by applicable law of the jurisdiction in which the drug is dispensed.
11. Drugs prescribed for uses other than uses approved by the Food and Drug Administration (FDA) under the Federal Food, Drug and Cosmetic Law and regulations. This exclusion will not apply with respect to drugs studied under an **Eligible Clinical Trial**.
12. Medical supplies, devices and equipment and non-medical supplies or substances regardless of their intended use.
13. Test agents and devices, excluding diabetic test agents.
14. Injectable Drugs used for the purpose of treating **Infertility**, unless otherwise covered by **HMO**.
15. Injectable drugs, except for insulin and contraceptives.
16. Prescription orders filled prior to the effective date or after the termination date of the coverage provided by this rider.
17. Replacement for lost or stolen prescriptions.
18. Performance, athletic performance or lifestyle enhancement drugs and supplies.
19. Drugs and supplies when not indicated or prescribed for a medical condition as determined by **HMO** or otherwise specifically covered under this rider or the medical plan.
20. Drugs dispensed by other than a **Participating Retail** or **Mail Order Pharmacy**, except as **Medically Necessary** for treatment of an emergency or **Urgent Care** condition.
21. Medication packaged in unit dose form. (Except those products approved for payment by **HMO)**.
22. Prophylactic drugs for travel.
23. Drugs recently approved by the FDA, but which have not yet been reviewed by the Aetna Health Pharmacy Management Department and Therapeutics Committee.
24. Drugs for the convenience of **Members** or for preventive purposes.
25. Drugs listed on the **Formulary Exclusions List (Restricted Drugs and Devices)** unless otherwise covered through a medical exception as described in this rider or unless otherwise covered under this rider.
26. Sildenafil citrate, phentolamine, apomorphine and alprostadil in oral, injectable and topical (including but not limited to gels, creams, ointments and patches) forms or any other form used internally or externally. Any prescription drug in oral, topical or any other form that is in a similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes unless otherwise covered under this rider.

27. Nutritional supplements.
28. Smoking cessation aids or drugs.
29. Growth hormones, except when used in the treatment of a congenital defect.
30. Drugs or medications in a **Therapeutic Drug Class** if one of the drugs or medications in that **Therapeutic Drug Class** is available over-the-counter (OTC).

B. **Limitations**:

1. A **Participating Retail** or **Mail Order Pharmacy** may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.

2. Non-emergency and non-**Urgent Care** prescriptions will be covered only when filled at a **Participating Retail Pharmacy** or the **Participating Mail Order Pharmacy**. **Members** are required to present their ID card at the time the prescription is filled. A **Member** who fails to verify coverage by presenting the ID card will not be entitled to direct reimbursement from **HMO**, and **Member** will be responsible for the entire cost of the prescription. Refer to the **Certificate** for a description of emergency and **Urgent Care** coverage. **HMO** will not reimburse **Members** for out-of-pocket expenses for prescriptions purchased from a **Participating Retail Pharmacy; Participating Mail Order Pharmacy** or a non-**Participating Retail** or **Mail Order Pharmacy** in non-emergency, non-**Urgent Care** situations. **HMO** retains the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to the Grievance Procedure section of the **Certificate**.

3. **Member** will be charged the **Non-Formulary Prescription Drug Copayment** for prescription drugs covered on an exception basis.

4. The Continuation and Conversion section of the **Certificate,** if any, is hereby amended to include the following provision: the conversion privilege does not apply to the **HMO** Prescription Plan.

Notice

Please be aware that administration of the definition of "negotiated charge" for Prescription Drug Expense Coverage for most plans has been changed to support the following:

> As to the Prescription Drug Expense Coverage:
> The amount **HMO** has established for each **prescription drug** obtained from a **Participating Retail**, **Mail Order**, or **Specialty Pharmacy Network Pharmacy**. The **Negotiated Charge** may reflect amounts **HMO** has agreed to pay directly to the **Participating Retail**, **Mail Order**, or **Specialty Pharmacy Network Pharmacy**, or to a third party vendor for the prescription drug, and may include an additional service or risk charge set by **HMO**.
>
> The **Negotiated Charge** does not include or reflect any amount **HMO**, an affiliate, or a third party vendor, may receive under a rebate arrangement between **HMO**, an affiliate or a third party vendor and a drug manufacturer for any prescription drug, including prescription drugs on the **Drug Formulary**.

Where permitted by law, this change has been, or will be made to all Member Plan Documents effective as of the first renewal date for the plan occurring after January 1, 2010.

AETNA HEALTH INC.
(NORTH CAROLINA)

AMENDMENT TO THE PRESCRIPTION PLAN RIDER

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc.Prescription Plan Rider is hereby amended as follows:

The Definition of "**Contracted Rate**", appearing in the Definitions section of the Prescription Drug Rider is hereby deleted and, all references to "**Contracted Rate**" are replaced by "**Negotiated Charge**" and the following definition is added to the Definitions section of the Prescription Drug Rider:

- **Negotiated Charge.** The compensation amount negotiated between **HMO** or an affiliate and a **Participating Retail Pharmacy**, **Participating Mail Order Pharmacy**, or **Specialty Pharmacy Network** pharmacy for **Medically Necessary** outpatient prescription drugs and insulin dispensed to a **Member** and covered under the **Member's** benefit plan. This negotiated compensation amount does not reflect or include any amount **HMO** or an affiliate may receive under a rebate arrangement between **HMO** or an affiliate and a drug manufacturer for any drug, including drugs on the **Drug Formulary**.

The Definitions section of the Prescription Plan Rider is amended to add the following:

- **Self-injectable Drug(s)**. Prescription drugs that are intended to be self administered by injection to a specific part of the body to treat certain chronic medical conditions. An updated copy of the list of covered **Self-injectable Drugs**, designated by **HMO** as eligible for coverage under this amendment, shall be available upon request by the **Member** or may be accessed at the **HMO** website, at www.aetna.com. The list is subject to change by **HMO** or an affiliate.

- **Specialty Pharmacy Network**. A network of **Participating** pharmacies designated to fill **Self-injectable Drugs** prescriptions.

The Additional Benefits section of the Prescription Plan Rider is amended to include the following benefits:

- **Self-injectable Drugs.**

  Self-injectable Drugs, eligible for coverage under this amendment, are covered when prescribed by a **Provider** licensed to prescribe federal legend prescription drugs or medicines. The initial prescription must be filled at a **Participating Retail Pharmacy, Participating Mail Order Pharmacy** or **Specialty Pharmacy Network** pharmacy. All refills must be filled by a **Participating Mail Order Pharmacy or Specialty Pharmacy Network** pharmacy. Coverage of **Self-injectable Drugs** may, in **HMO's** sole discretion, be subject to the **Precertification Program**, the **Step Therapy Program** or other **HMO** requirements or limitations.

  Food and Drug Administration (FDA) approved **Self-injectable Drugs**, eligible for coverage under this amendment, are covered when the off-label use of the drug has not been approved by the FDA for that indication, provided that such drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information), or the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer review journal. Coverage of off label use of these drugs may, in **HMO's** sole discretion, be subject to the **Precertification Program**, the **Step Therapy Program** or other **HMO** requirements or limitations.

  Member is responsible for the payment of the applicable **Copayment** for each prescription or refill as provided in the rider.

The exclusion for Injectable drugs, except for insulin in the Exclusions and Limitations section of the Prescription Plan Rider is hereby deleted and replaced with the following:

- Injectable drugs, except for insulin and **Self-injectable Drugs**.

Coverage is subject to the terms and conditions of the **Certificate.**

AETNA HEALTH INC.
(NORTH CAROLINA)

SCHEDULE OF BENEFITS

Plan Name: CHARTER OPEN ACCESS PLAN
Contract Holder Name: Government of the District of Columbia
Contract Holder Group Agreement Effective Date: January 1, 2013
Contract Holder Number: 172614
Contract Holder Locations: 047
Contract Holder Service Areas: NC01

BENEFITS

Benefit	Maximums
Maximum Out-of-Pocket Limit **Does not apply to Prescription Drug Benefits.**	
Individual Limit	**$3,500 per calendar year**
Family Limit	**$10,500 per calendar year**
The family Maximum Out-of-Pocket Limit is a cumulative Maximum Out-of-Pocket Limit for all family members. The family Maximum Out-of-Pocket Limit can be met by a combination of family members with no single individual within the family contributing more than the individual limit.	
Member must demonstrate the Copayment amounts that have been paid during the year.	
Maximum Benefit	**Unlimited per Member per lifetime**

OUTPATIENT BENEFITS

Benefit	Copayment
Primary Care Physician Services	
Adult Physical Examination including Immunizations	**$0 per visit**
Visits are subject to the following visit maximum:	
Adults 18-65 years old: 1 visit per 12-month period	
Adults over 65 years old: 1 visit per 12-month period	
Well Child Physical Examination including Immunizations	**$0 per visit**
Office Hours Visits	**$10 per visit**
After-Office Hours and Home Visits	**$15 per visit**

Specialist Physician Services	
Office Visits	**$20 per visit**
Routine Gynecological Exam(s) **1 visit(s) per 365 day period**	
Performed at a Primary Care Physician Office	**$0 per visit**
Performed at a Specialist Office	**$0 per visit**
Prenatal Visit(s) by the attending Obstetrician	**$0 per visit**
Outpatient Rehabilitation **Treatment over a 60 consecutive day period per incident of illness or injury beginning with the first day of treatment**	**$20 per visit**
Outpatient Facility Visits	**$20 per visit**
Diagnostic X-Ray Testing	**$0 per visit**
Complex Imaging Services, including, but not limited to: Magnetic Resonance Imaging (MRI); Computerized Axial Tomography (CAT); and Positron Emission Tomography (PET)	**$0 per visit**
Mammography **1 baseline mammogram for a woman age 35 but less than 40;** **1 mammogram every 2 years, or more frequently if recommended by a physician, for a woman age 40 but less than 50;** **1 mammogram every year for a woman age 50 or older; and** **A mammogram given at any time if recommended by a physician for a woman who has a personal or family history or breast cancer.**	**$0 per visit**
Diagnostic Laboratory Testing	**$0 per visit**
Outpatient Emergency Services **Hospital Emergency Room or Outpatient Department** **Emergency care received from a Non-participating Provider will be paid at the in-network benefit level.**	**$50 per visit**
Urgent Care Facility	**$25 per visit**
Ambulance	**$0 per trip**
Outpatient Mental Health Visits **Non-Clinically Significant Mental Illness** **Unlimited outpatient days per calendar year**	**$10 per visit**

Outpatient Mental Health Visits	
Clinically Significant Mental Illness	**$20 per visit**
The following illnesses are not subject to any of the above durational limits:	
(1) Bipolar Disorder.	
(2) Major Depressive Disorder.	
(3) Obsessive Compulsive Disorder.	
(4) Paranoid and Other Psychotic Disorder.	
(5) Schizoaffective Disorder.	
(6) Schizophrenia.	
(7) Post-Traumatic Stress Disorder.	
(8) Anorexia Nervosa.	
(9) Bulimia.	
Outpatient Substance Abuse Visits	
Detoxification	**$10 per visit/day**
Outpatient Substance Abuse Visits	
Rehabilitation:	
Unlimited visits per calendar year	**$10 per visit/day**
Outpatient Surgery	**$50 per visit**
Outpatient Home Health Visits	
Limited to 3 intermittent visit(s) per day provided by a Participating home health care agency; 1 visit equals a period of 4 hours or less.	
Unlimited visits per calendar year	**$0 per visit**
Outpatient Hospice Care Visits	**$0 per visit**
Injectable Medications Drugs - not applicable to medicines necessary for the treatment of diabetes.	**$10 per visit or per prescription or refill**
Depending on where the Covered Health Service is provided, benefits for diabetes will be the same as those stated under this schedule for similar types of service.	

INPATIENT BENEFITS

Benefit	**Copayment**
Acute Care	**$100 per admission**
Inpatient and Partial Hospitalization Days for Non-Clinically Significant Mental Illness	
Maximum of Unlimited days per calendar year	**$100 per admission**
This maximum benefit may also be combined with Partial Hospitalization days for Non-Clinically Significant Mental Illness.	

Inpatient Clinically Significant Mental Illness **The following illnesses are not subject to any of the above durational limits:** **(1) Bipolar Disorder.** **(2) Major Depressive Disorder.** **(3) Obsessive Compulsive Disorder.** **(4) Paranoid and Other Psychotic Disorder.** **(5) Schizoaffective Disorder.** **(6) Schizophrenia.** **(7) Post-Traumatic Stress Disorder.** **(8) Anorexia Nervosa.** **(9) Bulimia.**	**$100 per admission**
Substance Abuse **Detoxification**	**$100 per admission**
Substance Abuse **Rehabilitation:** **Maximum of Unlimited days per 365 day period**	**$100 per admission**
Maternity	**$100 per admission**
Skilled Nursing Facility **Maximum of 60 days per calendar year**	**$100 per admission (waived if a Member is transferred from a Hospital to a Skilled Nursing Facility)**
Hospice Care	**$0 per admission (waived if a Member is transferred from a Hospital to a Hospice Care facility)**

ADDITIONAL BENEFITS

Benefit	**Copayment**
Eye Examination by a Specialist (including refraction) as per schedule in the Certificate	**$20 per visit**
Subluxation	**$10 per visit**
Durable Medical Equipment (DME)	**50% (of the cost) per item**
DME Maximum Benefit	**Unlimited per Member per calendar year**
Diabetic Equipment, Supplies and Education	**$10 per visit**
Routine Prostate Specific Antigen Tests **Maximum tests per calendar year - One or more as recommended by a Physician.**	**$0 per routine prostate specific antigen test**

Note: In no event will the Member be responsible for any amounts above the percentage of the contracted rate specified above.

Non-Surgical treatment of temporomandibular joint dysfunction shall be limited to $3,500 per Member per lifetime.

Subscriber Eligibility: **All active full-time employees of the Contract Holder who regularly work at least the minimum number of hours per week as defined by the Contract Holder and agreed to by HMO.**

Eligible for benefits on the date of hire.

Dependent Eligibility: **A dependent unmarried child of the Subscriber as described in the Eligibility and Enrollment section of the Certificate who is:**

i. **under 26 years of age; or**

ii. **under 26 years of age, dependent on a parent or guardian Member, and attending a recognized college or university, trade or secondary school on a full-time basis; or**

iii. **chiefly dependent upon the Subscriber for support and maintenance, and is 19 years of age or older but incapable of self-support due to mental or physical incapacity, either of which commenced prior to: 26, or if a student, 26.**

Termination of Coverage: **Coverage of the Subscriber and the Subscriber's dependents who are Members, if any, will terminate on the earlier of the date the Group Agreement terminates or immediately following the date on which the Subscriber ceased to meet the eligibility requirements.**

Coverage of Covered Dependents will cease immediately following the date on which the dependent ceased to meet the eligibility requirements.

AETNA HEALTH INC.
(NORTH CAROLINA)

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. **Schedule of Benefits** is hereby amended as follows:

Subluxation	
20 visits per calendar year	**$10 per visit**

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

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

If your Aetna plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, then until you make this designation, Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

If your Aetna plan allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your Aetna plan provides coverage for obstetric or gynecological care and requires the designation of a primary care provider then you do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

IMPORTANT HEALTH CARE REFORM INFORMATION

Some language changes in response to recent changes to preventive services coverage and women's preventive health coverage under the Federal Affordable Care Act (ACA) may not be included in the enclosed certificate of coverage. This may be because the language is still pending regulatory review and approval. However, please note that Aetna is administering medical and outpatient prescription drug coverage in compliance with the applicable components of the ACA.

The following is a summary of the recent changes to preventive services coverage and women's preventive health coverage under the ACA that applies to non-grandfathered plans that are not otherwise exempt from the requirements. Preventive services, as required by ACA, will be paid without cost-sharing such as payment percentages, copayments and deductibles.

For details on any benefit maximums and the cost-sharing under your plan, call the Member Services number on the back of your ID card.

1. An annual routine physical exam for covered persons through age 21.

2. For covered females:

    - Screening and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:

        - Screening and counseling services, such as:
            - Interpersonal and domestic violence;
            - Sexually transmitted diseases; and
            - Human Immune Deficiency Virus (HIV) infections.

        - Screening for gestational diabetes.

        - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older and limited to once every three years.

    - A routine well woman preventive exam office visit, including Pap smears, in accordance with the recommendations by the Health Resources and Services Administration.

3. Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:

    - Preventive counseling visits and/or risk factor reduction intervention;
    - Medical nutrition therapy;
    - Nutritional counseling; and
    - Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

    Benefits under your plan may be subject to visit maximums.

4. Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.

    Benefits under your plan may be subject to visit maximums.

5. Screening and counseling services to aid you to stop the use of tobacco products. Coverage includes:

   - Preventive counseling visits;
   - Treatment visits; and
   - Class visits.

   Benefits under your plan may be subject to visit maximums.

6. Prenatal care received by a pregnant female. Coverage is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).

7. Comprehensive lactation support, (assistance and training in breast-feeding), and counseling services provided by a certified lactation support provider, in a group or individual setting, to females during pregnancy and in the post partum period.

   The rental or purchase of breast-feeding durable medical equipment for the purpose of lactation support (pumping and storage of breast milk), and the purchase of the accessories and supplies needed to operate the item. Aetna reserves the right to limit the payment of charges up to the most cost-efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of Aetna.

   Benefits under your plan may be subject to maximums.

8. For females with reproductive capacity, coverage includes:

   - FDA-approved contraceptive methods including certain FDA-approved generic drugs, implantable devices, sterilization procedures and patient education and counseling for women with reproductive capacity.

   - Counseling services provided by a physician in either a group or individual setting on contraceptive methods. Benefits may be subject to visit maximums.

   - Female voluntary sterilization procedures and related services and supplies including tubal ligation and sterilization implants. Coverage does not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.

   - FDA-approved female generic emergency contraceptive methods that are prescribed by your physician. The prescription must be submitted to the pharmacist for processing.

   Additional exemptions may apply to plans that are sponsored by religious employers or religious organizations and meet certain criteria which exempt the health plan from the federal requirement to provide coverage for contraceptive services.

   The drug list is subject to change. Visit "Medication Search" on your secure member website at www.aetna.com for the most up-to-date information on drug coverage for your plan.