Dear Aetna Member:

To make it easier for you to make informed health care decisions, we’ve put your Summary of Coverage/Schedule of Benefits and your Booklet on line on your Aetna Navigator secure member website. Your Summary of Coverage/Schedule of Benefits and your Booklet provide key detail about your health care benefits, including your share of the cost and which services are covered. You can log into Aetna Navigator on www.aetna.com. When you get to your secure home page, just select Coverage & Benefits.

If you change Aetna Health plans or if your coverage changes, you can always rely on Aetna Navigator to display the most up to date versions of the Summary of Coverage/Schedule of Benefits and your Booklet.

If you do not have access to the Internet or would prefer a paper copy, please contact your employer’s benefits office.

Sincerely,

Aetna
AETNA HEALTH INC.
(Maine)

CERTIFICATE OF COVERAGE

This Certificate of Coverage ("Certificate") is part of the Group Agreement ("Group Agreement") between Aetna Health Inc., referred to as HMO, and the Contract Holder. The Group Agreement sets forth the terms and conditions of coverage. The Certificate describes covered health care benefits. Provisions of this Certificate include the Schedule of Benefits, any riders; and any amendments; endorsements; inserts; or attachments. These may be delivered with the Certificate or added after issue.

HMO agrees with the Contract Holder to provide coverage for benefits. These are provided according with the conditions; rights; and privileges as set forth in this Certificate. Members covered under this Certificate are subject to all the conditions and provisions of the Group Agreement.

Coverage is not provided for any services received before coverage starts or after coverage ends, except as shown in the Continuation and Conversion section of this Certificate.

Some words have specific meanings when used in this Certificate. The defined terms appear in bold type with initial capital letters. The defined 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 federal law that apply and the laws of Maine.

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

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

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

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

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

Important

Unless it is specifically provided, no Member has the right to receive the benefits of this plan for health care services or supplies furnished after termination of coverage. Benefits of this plan are available only for services or supplies given: (a) during the term the coverage is in effect; and (b) while the person claiming the benefits is actually covered by the Group Agreement. Benefits may be changed while this plan is in effect, as set forth under the terms of the Group Agreement; or upon renewal. If benefits are changed, the revised benefits (including any reduction in; or elimination of benefits) apply for services or supplies furnished on or after the effective date of the changes. There is no vested right to receive the benefits of the Group Agreement.
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HMO PROCEDURE

A. Selecting a Participating Primary Care Physician:

At the time of enrollment, each Member should select a Designated Participating Primary Care Physician (PCP) or a Non-Designated Participating Primary Care Physician (PCP) from the Directory of Participating Providers to access Covered Benefits. The choice of a PCP is made only by the Member. If the Member is a minor or incapable of selecting a PCP, the Subscriber should select a PCP on the Member’s behalf.

B. The Primary Care Physician.

The PCP coordinates a Member’s medical care; as appropriate; either by providing treatment or by giving Referrals. It does so to direct the Member to another Participating Provider. The PCP can also order lab tests and x-rays; prescribe drugs or therapies; and arranges hospital stays. Except in a Medical Emergency or for certain direct access Specialist benefits as set forth in this Certificate, only those services which are given by or referred by a Member’s PCP will be covered. Covered Benefits are set forth in the Covered Benefits section. It is a Member’s responsibility to consult with the PCP in all matters having to do with the Member’s medical care.

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

In certain cases where a Member needs ongoing care from a Specialist, the Member may get a standing Referral to such Specialist. Please refer to the Covered Benefits section of this Certificate for details.

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

C. Availability of Providers.

HMO cannot guarantee the availability or continued participation of a given Provider. Either HMO or any Participating Provider may end the Provider contract or limit the number of Members that will be accepted as patients. If the PCP first selected cannot accept any more patients, the Member will be told and given an opportunity to choose another PCP. The Member must then work with HMO to select another PCP. Until a PCP is chosen, benefits are limited to coverage for Medical Emergency care.

D. Changing a PCP.

A Member may change their PCP at any time. He can do so by calling the Member Services toll-free telephone number. This is 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 ask a change form or for help in filling out that form. The change will be effective upon HMO’s receipt and approval of the request.

E. Ongoing Reviews.

HMO conducts ongoing reviews of those services and supplies which are suggested or provided by Health Professionals to figure out if such services and supplies are Covered Benefits. If HMO determines that the suggested services and supplies are not Covered Benefits, the Member will be told. If a Member wishes to appeal such determination, the Member may then ask HMO to seek a review of the determination. Please refer to the Grievance Procedure section of this Certificate.

F. Pre-authorization.
Some services and supplies under this Certificate may require pre-authorization. HMO will determine if they are Covered Benefits under this Certificate.

G. Continuity of Care

Existing Members
The following applies when a Hospital or Physician:

- either voluntarily or involuntarily stops participation in this HMO plan as a Designated Network Provider; or
- stops participation with HMO as a Participating Provider for reasons other than imminent harm to patient care; a determination of fraud; or a final disciplinary action by a state licensing board that impairs the Participating Provider's ability to practice.

HMO will allow a Member to remain in coverage for an ongoing course of treatment with the Member's current Hospital or Physician during a transitional period.

Coverage shall continue for up to 90 days from the date of notice to the Member from HMO that:

- the Participating Provider is no longer a Designated Participating Provider under the HMO plan; or
- the Provider has stopped participation with HMO as a Participating Provider.

The notice will include specific instructions on how to request continuity of care during the transitional period.

If a Member has entered the second trimester of pregnancy, the transitional period will include the period of time required for postpartum care, directly related to the delivery that is provided to the Member.

The coverage will be authorized by HMO for the transitional period only if the Hospital or Physician agrees to:

- accept reimbursement by HMO at the Contracted Rate and cost-sharing established by HMO that was in effect prior to the start of a transitional period as payment in full;
- adhere to HMO's quality standards;
- provide medical information to HMO related to such care; and
- adhere to HMO's policies and procedures.

This clause will not be taken to require HMO to provide coverage for benefits that would not be covered under this Certificate.
New Enrollees
Coverage levels differ based upon whether the Hospital or Physician: (a) has or; (b) does not have a contract with HMO.

If a Member's current Hospital or Physician has a contract with HMO; or if the Member's current Hospital or Physician is classified as a Non-Designated Participating Provider under the HMO plan; new enrollees may stay on an ongoing course of treatment with their current Hospital or Physician. They may do so for a transitional period of up to 60 days from the effective date of enrollment. If a Member has entered the second trimester of pregnancy as of the effective date of enrollment, the transitional period will include the period of time that postpartum care, directly related to the delivery, is provided to the Member. The Member must fill a Transition of Coverage Request form and send it to HMO. A Member may call Member Services at the number on the back of the ID card for a copy of this form. If authorized by HMO, coverage will be provided for the transitional period. But, but only if the Hospital or Physician agrees to:

- accept payment by HMO at the Contracted Rate and Designated Participating Provider cost-sharing agreed by HMO that was in effect prior to the start of a transitional period as payment in full;
- adhere to HMO's quality standards;
- provide medical information to HMO related to such care; and
- adhere to HMO's policies and procedures.

If a Member's current Hospital or Physician does not have a contract with HMO, new enrollees may continue an ongoing course of treatment with their current Hospital or Physician. They may do so for a transitional period of up to 60 days from the effective date of enrollment. If a Member has entered the second trimester of pregnancy as of the effective date of enrollment, the transitional period shall include the period of time that postpartum care, directly related to the delivery, is provided to the Member. The Member must complete a Transition of Coverage Request form and send it to HMO. A Member may call Member Services at the number on the back of the ID card for a copy of this form. If authorized by HMO, coverage will be provided for the transitional period but only if the Hospital or Physician agrees to:

- accept reimbursement by HMO at the Contracted Rate and Non-Designated Participating Provider cost-sharing established by HMO that was in effect prior to the start of a transitional period as payment in full;
- adhere to HMO's quality standards;
- provide medical information to HMO related to such care; and
- adhere to HMO's policies and procedures.

This clause shall not be taken to require HMO to provide coverage for benefits that would not be covered under this Certificate.

H. Participating Providers

This HMO plan allows access to covered services and supplies through a broad network of health care providers and facilities. Participating Providers have agreed with HMO; an affiliate or third party vendor; to provide health care services and supplies to HMO plan Members. The HMO plan includes Participating Providers that are listed in this form as Designated Participating Providers and Non-Designated Participating Providers.

**Important Note:**
Under this Plan, some Participating Providers have elected not to participate and are not considered Non-Designated Participating Providers. They will be treated as Non-Participating Providers.

Designated Participating Providers and Non-Designated Participating Providers
This plan provides preferred benefit coverage and access to covered services and supplies. This takes place through a network of health care providers and facilities that are unique to a Member's plan. The network has been split into two groups. In this plan, the two groups of Participating Providers are called Designated...
Participating Providers and Non-Designated Participating Providers. A Member's cost sharing will be lower when a Member uses Designated Participating Providers. They will be higher when a Member uses Non-Designated Participating Providers. Both groups of Participating Providers are set forth in the printed Directory and the on-line version of the Directory via DocFind at www.aetna.com. Members should be sure to look at the appropriate Directory that applies to their plan. Different HMO plans use different networks of Providers.
ELIGIBILITY AND ENROLLMENT

A. Eligibility.

1. To be eligible to enroll as a Subscriber, an individual must:
   a. meet the eligibility agreed upon by the Contract Holder and HMO; and
   b. live or work in the Service Area.

2. In order to enroll as a Covered Dependent, the Contract Holder must provide dependent coverage for Subscriber. The dependent must be:
   a. the legal spouse of a Subscriber under this Certificate; or
   b. a dependent child, not married (including natural; foster; step; legally adopted children; children placed for adoption; a child under court order;) who meets the eligibility requirements set forth in this Certificate; and on the Schedule of Benefits.

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

   Note: If the Member is covered as a dependent child, and Aetna is requested by a parent of the Member, HMO shall provide that parent with:

   • An explanation of the payment or denial of any claim filed on behalf of the child, except to the extent that Aetna has the right to withhold consent and does not affirmatively consent to notifying the parent;
   • An explanation of any proposed change in the terms and conditions of the Plan; or
   • Reasonable notice that the Plan may lapse, but only if you have provided HMO with the address at which you may be notified.

   In addition, any parent who is able to provide the information necessary for HMO to process a claim must be permitted to authorize the filing of any claims under the Plan.

3. A Member who lives outside the Service Area has to choose a PCP. Also he has to return to the Service Area for Covered Benefits. The only services covered out of the Service Area are Emergency Services and Urgent Care.

B. Enrollment.

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

1. Newly Eligible Persons and Eligible Dependents:

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

2. Open Enrollment Period:
Eligible persons or dependents who are eligible, but do not enroll as stated above, may be enrolled during any later Open Enrollment Period. The person must submit all needed enrollment information and Premium payment to HMO.

3. Enrollment of Newly Eligible Dependents:
   a. Newborn Children.

      A newborn child is covered for 31 days from the date of birth. To continue coverage beyond this initial period, the child must be enrolled in HMO within the initial 31 day period. The coverage might not need the payment of an additional Premium for a Covered Dependent. But, the Subscriber must still enroll the child within 31 days after the date of birth. The coverage for newly born; adopted children; and children placed for adoption will cover an injury and sickness. This will include any needed care and treatment of congenital defects and birth abnormalities. Coverage includes needed transport costs from place of birth to the nearest special Participating care center.

   b. Adopted Children.

      A legally adopted child or a child for whom a Subscriber is a court appointed legal guardian; and who meets the definition of a Covered Dependent; will be deemed a dependent. This will be from the date of adoption; or upon the date the child was placed for adoption with the Subscriber. “Placed for adoption” means that the Subscriber assumes and retains a legal obligation for total or partial support of a child in anticipation of adoption of the child. The Subscriber must make a written request for coverage within 31 days of the date the child is adopted; or placed with the Subscriber for adoption.

4. Special Rules Which Apply to Children.
   a. Qualified Medical Child Support Order.

      Coverage is available for a dependent child that does not live with a Subscriber and who lives outside the Service Area. This will happen, if there is a qualified medical child support order that requires the Subscriber to provide such coverage for a non-resident child. The child must meet the definition of a Covered Dependent. Also, the Subscriber must make a written request for coverage within 31 days of the court order.

   b. Handicapped Children.

      Coverage is available for a child who is chiefly dependent upon the Subscriber for support and maintenance. The child must be 19 years of age or older but not capable of self-support due to mental or physical incapacity. The incapacity must have started prior to the age the child would have lost eligibility. In order to continue coverage for a such child, the Subscriber must give proof of the child’s incapacity and dependent status. It must be given to HMO within 31 days of the date the child's coverage would otherwise end. Proof of continued incapacity, including a medical examination, must be given to HMO when asked, but not sooner than annually. It must be given starting after the 2 year period that starts after the child's attainment of the age set forth on the Schedule of Benefits. This eligibility provision will no longer apply on the date the dependent’s incapacity ends.

5. Notification of Change in Status.
A Member will be responsible to tell HMO of any changes which affect the Member’s coverage under this Certificate. But, a different notification process may be agreed to between HMO and Contract Holder. Such status changes include, but are not limited to, change of address; change of Covered Dependent status; and enrollment in Medicare or any other group health plan of any Member. Additionally, if requested, a Subscriber must provide to HMO, within 31 days of the date of the request, evidence satisfactory to HMO that a dependent meets the eligibility requirements described in this Certificate.

6. Special Enrollment Period.

An eligible individual and eligible dependents may be enrolled during special enrollment periods. A special enrollment period may apply when: (a) an eligible person or eligible dependent loses other health coverage; or (b) when an eligible person gets a new eligible dependent through marriage; birth; adoption; or placement for adoption.

**Special Enrollment Period for Certain Persons Who Lose Other Health Coverage:**

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

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

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

c. the eligible person or eligible dependent loses coverage under the other group health plan or other health insurance coverage for 1 of these 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 ended; or
   
   ii. the other coverage is a group health plan or other health insurance coverage; and the other coverage has ended as a result of: loss of eligibility for the coverage; or employer contributions for the other coverage have ended.

Loss of eligibility includes:

- a loss of coverage due to legal separation; divorce or death; end 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;
- end of HMO coverage due to Member action- movement outside of the HMO’s service area; and also the end of health coverage; including Non-HMO, due to the end of the plan.
- plan no longer offers coverage to a group of similarly situated persons;
- the end of a dependent’s status as an eligible dependent
- the end of the benefit package

Loss of eligibility does not include a loss due to failure of the person or the participant to pay Premiums when due; or due to the end of coverage for cause as referenced in the Termination of Coverage section of this Certificate; and
The **Effective Date of Coverage** will be the first day of the first calendar month that follows the date the HMO gets the request for enrollment.

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 so enrolled, the eligible person and other eligible dependents) may be enrolled during a special enrollment period.

The special enrollment period is a period of 31 days, that starts on the date of the marriage; birth; adoption or placement for adoption (as the case may be). If a 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 person or the eligible dependents that enroll during a special enrollment period will not be subject to late enrollment provisions, if any, described in this *Certificate*.

**Late Enrollment.**

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

C. **Effective Date of Coverage.**

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

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

If a Member is an inpatient in a Hospital on the **Effective Date of Coverage**, the Member will be covered as of that date. Such services are not covered if: the Member is covered by another health plan on that date; and the other health plan is responsible for the cost of the services. HMO will not cover any service that is not a *Covered Benefit* under this *Certificate*. To be covered, the Member must use *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 set forth below, according to the terms and conditions of this Certificate. For benefits to be covered, they must be Medically Necessary. HMO may determine whether any benefit provided under the Certificate is Medically Necessary. 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.

In certain cases, a Designated Participating Provider or a Member’s PCP may seek prior authorization to direct the Member to a Non-Designated Participating Provider. If such prior authorization is given by HMO prior to the treatment, then such services will be subject to the cost-sharing that apply to Designated Participating Providers, as listed on the Schedule of Benefits. If a Designated Participating Provider or a Member’s PCP refers the Member to a Non-Designated Participating Provider without prior authorization from HMO, then such services will be subject to the cost-sharing that apply to Non-Designated Participating Providers.

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

To be Medically Necessary, the service or supply must:

- meet generally accepted standards of medical practice;
- be clinically appropriate in terms of type; frequency; extent, site and duration;
- be demonstrated through scientific evidence to be effective in improving health outcomes;
- be representative of “best practices” in the medical profession; and
- be not primarily for the convenience of the Member or Physician.

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

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

A Member might have questions regarding coverage under this Certificate. If so, the Member may call the Member Services toll-free telephone number listed on the Member’s identification card.

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

EXCEPT FOR DIRECT ACCESS SPECIALIST BENEFITS OR IN A MEDICAL EMERGENCY OR URGENT CARE SITUATION AS SET FORTH IN THIS CERTIFICATE, THESE 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.

NOTIFICATION PRIOR TO CANCELLATION OF COVERAGE DUE TO COGNITIVE IMPAIRMENT OF FUNCTIONAL INCAPACITY

HMO WILL NOTIFY THE MEMBER, AND ANY OTHER PERSON DESIGNATED BY THE MEMBER, PRIOR TO CANCELLATION OF COVERAGE FOR NON-PAYMENT OF PREMIUM AS A RESULT OF MEMBER’S COGNITIVE IMPAIRMENT OR PHYSICAL INCAPACITY.

Preventive Care

1. The recommendations and guidelines of the:
   - Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
   - United States Preventive Services Task Force;
     - Health Resources and Services Administration; and
     - American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents

   As referenced throughout this Preventive Care Benefit may be updated periodically. This Plan is subject to updated recommendations or guidelines that are issued by these organizations beginning on the first day of the plan year, one year after the recommendation or guideline is issued.

2. If any diagnostic x-rays; lab; or other tests or procedures are ordered; or given; for with any of the Preventive Care Benefits set forth below, those diagnostic x-rays; lab or other tests or procedures will not be covered as Preventive Care Benefits. Those that are Covered Benefits will be subject to the cost-sharing that applies to those services under this Plan.

3. Refer to the Schedule of Benefits for information about cost-sharing and maximums that apply to Preventive Care benefits.

4. To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your physician or contact Member Services by logging on to your Aetna Navigator® secure member website at www.aetna.com or at the toll-free number on your ID card. This information can also be found at the www.HealthCare.gov website.

Routine Physical Exam Benefit

Covered Benefits include office visits to a Member's Primary Care Physician (PCP) for routine physical exams; including routine vision and hearing screenings given as part of the routine physical exam. A routine exam is a medical exam given by a PCP for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force;
Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For females, screenings 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 those on:
  - 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.

For covered newborns, an initial Hospital check up.

Benefits for the routine physical exam services above may be subject to visit maximums as shown in the Schedule of Benefits.

For details on the frequency and age limits that apply to Routine Physical Exam Benefit, Members may contact their Physician or Member Services by logging onto the Aetna Navigator website www.aetna.com, or calling the toll-free number on the back of the ID card.

Benefit Limitations:
Unless specified above, not covered under this benefit are:

- Services which are covered to any extent under any other part of this Plan;
- Services which are for diagnosis or treatment of a suspected or identified illness or injury;
- Exams given while the Member is confined in a Hospital or other facility for medical care;
- Services not given by a Physician or under his or her direction; and
- Psychiatric, psychological, personality or emotional testing or exams.

Preventive Care Immunizations Benefit

Covered Benefits include:

- Immunizations for infectious diseases; and
- The materials for administration of immunizations;

provided by a Member's PCP or a facility. The immunizations must be recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Benefit Limitations:
Not covered under this benefit are:

- Services which are covered to any extent under any other part of this Plan; and
- Immunizations that are not considered preventive care such as those required due to a Member's employment or travel.

Preventive Care Drugs and Supplements

Covered Benefits include preventive care drugs and supplements (including over-the-counter drugs and supplements) obtained at a pharmacy. They are covered when they are:

- prescribed by a Physician;
- obtained at a pharmacy; and
- submitted to a pharmacist for processing.

The preventive care drugs and supplements covered under this plan include, but may not be limited to:

- Aspirin: Benefits are available to adults.
- **Oral Fluoride Supplements**: Benefits are available to pre-school children whose primary water source is deficient in fluoride.
- **Folic Acid Supplements**: Benefits are available to adult females planning to become pregnant or capable of pregnancy.
- **Iron Supplements**: Benefits are available to children without symptoms of iron deficiency. Coverage is limited to children who are at increased risk for iron deficiency anemia.
- **Vitamin D Supplements**: Benefits are available to adults to promote calcium absorption and bone growth in their bodies.

**Reimbursement of Preventive Care Drugs and Supplements at a Pharmacy**

You will be reimbursed by HMO for the cost of the preventive care drugs and supplements. You must submit proof of loss to HMO that you purchased a preventive care drug or supplement at a pharmacy. “Proof of loss” means a copy of the receipt that contains the Prescription information provided by the pharmacist (it is attached to the bag that contains the preventive care OTC drug or supplement).

Refer to the provisions Reporting of Claims and Payment of Benefits later in this booklet-certificate for information. You can also contact Member Services by logging onto the HMO website at www.aetna.com or calling the toll-free number on the back of the ID card.

**Risk Reducing Breast Cancer Prescription Drugs**

**Covered Benefits** include Prescription Drugs when prescribed by a Prescriber and the Prescription is submitted to the pharmacist for processing for a woman who is at:
- Increased risk for breast cancer, and
- Low risk for adverse medication side effects

Coverage of preventive care drugs and supplements will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.

**Important Note:** For details on the guidelines and the current list of covered preventive care drugs and supplements, including risk reducing breast cancer Prescription Drugs, contact Member Services by logging on to your Aetna Navigator® secure member website at www. Aetna.com or at the toll-free number on your ID card.

Refer to the Schedule of Benefits for the cost-sharing and supply limits that apply to these benefits.

**Well Woman Preventive Visits Benefit**

- **Covered Benefits** include a routine well woman preventive exam office visit, including Pap smears, provided by a Member's PCP, Physician, obstetrician, or gynecologist in accordance with the recommendations by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given by a Physician for a reason other than to diagnose or treat a suspected or identified illness or injury; and
- Outline preventive care breast cancer genetic counseling and breast cancer (BRCA) gene blood testing. **Covered Benefits** include charges made by a Physician and lab for the BRCA gene blood test and charges made by a genetic counselor to interpret the test results and evaluate treatment.

These benefits will be subject to any age; family history; and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and
• Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

Benefits for the well woman preventive visit services above are subject to visit maximums as shown in the Schedule of Benefits.

Benefit Limitations:
Unless specified above, not covered under this benefit are:
• Services which are covered to any extent under any other part of this Plan;
• Services which are for diagnosis or treatment of a suspected or identified illness or injury;
• Exams given while the Member is confined in a Hospital or other facility for medical care;
• Services not given by a Physician or under his or her direction; and
• Psychiatric, psychological, personality or emotional testing or exams; and
• Services and supplies furnished by a non-Participating Provider.

Screening and Counseling Services Benefit.

Covered Benefits include the following services provided by a Member's PCP or Physician, as applicable, in an individual or group setting:

Obesity and Healthy Diet Counseling Benefit.

Covered Benefits include screening and counseling services to aid in weight reduction due to obesity. Coverage includes:
• Preventive counseling visits and/or risk factor reduction intervention;
• 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 for the screening and counseling services above are subject to the visit maximums as shown in the Schedule of Benefits.

Misuse of Alcohol and/or Drugs Benefit.

Covered Benefits include 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 for the screening and counseling services above are subject to visit maximums as shown later in this amendment.

Use of Tobacco Products Benefit.

Covered Benefits include screening and counseling services to aid in the cessation of the use of tobacco products.

Coverage includes:
• Preventive counseling visits;
• Treatment visits; and
• Class visits;

to aid in the cessation of the use of tobacco products.

Tobacco product means a substance containing tobacco or nicotine including:
- Cigarettes;
- Cigars;
- Smoking tobacco;
- Snuff;
- Smokeless tobacco; and
- Candy-like products that contain tobacco.

Benefits for the screening and counseling services above are subject to visit maximums as shown in the Schedule of Benefits.

**Sexually Transmitted Infection Counseling.**

**Covered Benefits** include the counseling services to help you prevent or reduce sexually transmitted infections.

**Genetic Risk Counseling for Breast and Ovarian Cancer.**

**Covered Benefits** include the counseling and evaluation services to help you assess whether or not you are at risk of breast and ovarian cancer.

**Benefit Limitations:**
Unless specified above, not covered under this benefit are services which are covered to any extent under any other part of this Certificate.

**Routine Cancer Screenings Benefit.**

**Covered Benefits** include, but are not limited to, the following routine cancer screenings:
- Mammograms;
- Fecal occult blood tests;
- Digital rectal exams;
- Prostate specific antigen (PSA) tests;
- Sigmoidoscopies;
- Double contrast barium enema (DCBE); and
- Colonoscopies; (removal of polyps performed during a screening procedure is a **Covered Benefit**); and
- Lung cancer screenings.

These benefits will be subject to any age, family history and frequency guidelines that are:
- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

For details on the frequency and age limits that apply to Routine Cancer Screenings Benefit, **Members** may contact their **Physician** or **Member Services** by logging onto the Aetna Navigator website www.aetna.com, or calling the toll-free number on the back of the ID card.

As to routine gynecological exams performed as part of a routine cancer screening, the **Member** may go directly to a **Participating** obstetrician (OB), gynecologist (GYN), obstetrician/gynecologist (OB/GYN). See the **Direct Access Specialist Benefits** section of the **Certificate**, for a description of this provision.

**Benefit Limitations:**
Unless specified above, not covered under this benefit are services which are covered to any extent under any other part of this Plan.
Prenatal Care Benefit.

Prenatal care will be covered as Preventive Care for services received by a pregnant female in a PCP, Physician's, OB-GYN, obstetrician's, or gynecologist's office but only to the extent described below.

Coverage for prenatal care under this benefit 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; fetal heart rate check and fundal height).

Benefit Limitations:
Unless specified above, not covered under this benefit are:
- Services which are covered to any extent under any other part of this Plan; and
- Services for maternity care (other than prenatal care as described above).

Important Note:
Refer to the:
- Maternity Care and Related Newborn Care Benefits section of the Certificate; and
- Prenatal Care Services, Delivery Services and Postpartum Care Services cost-sharing in the Schedule of Benefits;

for more information on coverage for services related to maternity care under this Plan.

Comprehensive Lactation Support and Counseling Services Benefit.

Covered Benefits include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy or at any time following delivery, for breast-feeding by a certified lactation support provider. Covered Benefits also include the rental or purchase of breast feeding equipment as described below.

Lactation support and lactation counseling services are Covered Benefits when provided in either a group or individual setting. Benefits for lactation counseling services are subject to the visit maximum shown later in this amendment.

Breast Feeding Durable Medical Equipment.

Covered Benefits includes the rental or purchase of breast feeding Durable Medical Equipment for the purpose of lactation support (pumping and storage of breast milk) as follows.

Breast Pumps.

Covered Benefits include:
- The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a Hospital.
- The purchase of:
  - An electric breast pump (non-hospital grade),. A purchase will be covered once every three years; or
  - A manual breast pump. A purchase will be covered once per pregnancy.
- If an electric breast pump was purchased within the previous one year period, the purchase of another breast pump will not be covered until a three year period has elapsed from the last purchase.
Breast Pump Supplies.

Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

Coverage for the purchase of breast pump equipment is limited to one item of equipment; for the same or similar purpose; and the accessories and supplies needed to operate the item. A Member is responsible for the entire cost of any additional pieces of the same or similar equipment purchased or rented for personal convenience or mobility.

HMO reserves the right to limit Covered Benefits 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.

Benefit Limitations:
Unless specified above, not covered under this benefit are services which are covered to any extent under any other part of this Plan.

Family Planning Services - Female Contraceptives Benefit.

Important Note:
For a list of the types of female contraceptives covered under this plan, refer to the section What the Pharmacy Benefit Covers and the Contraceptives benefit later in this Certificate.

For females with reproductive capacity, Covered Benefits include those services and supplies that are provided to a Member to prevent pregnancy. All contraceptive methods, services and supplies covered under this benefit must be approved by the U.S. Food and Drug Administration (FDA).

Contraceptives.

Covered Benefits include charges made by a Physician or pharmacy for:

- Services and supplies needed to administer or remove a covered contraceptive Prescription Drug or device;
- Female oral and injectable contraceptive that are Biosimilar Prescription Drugs, Brand Name Prescription Drugs and Generic Prescription Drugs;
- Female contraceptive devices that are generic devices and brand name devices;
- FDA-approved female:
  - Biosimilar, brand name and generic emergency contraceptives;
  - Brand name and generic over-the-counter (OTC) emergency contraceptives for which a Prescription is not needed.

Coverage is limited to 1 emergency contraceptive(s) per month.

- FDA-approved female brand name and generic over-the-counter (OTC) contraceptives. Coverage is limited to one per day and a 30 day supply per prescription.

FDA-approved male brand name and generic over-the-counter (OTC) contraceptives. Coverage is limited to one per day and a 30 day supply per Prescription.

When contraceptive methods are obtained at a pharmacy, Prescriptions must be submitted to the pharmacist for processing.

Reimbursement of Over-the-Counter (OTC) Contraceptives at a Pharmacy.

The FDA-approved OTC contraceptives described above are covered under this Plan when they are:

- prescribed by a Physician;
- obtained at a pharmacy; and
• submitted to a pharmacist for processing.

You will be reimbursed by HMO for the cost of the OTC contraceptive when you submit proof of loss to HMO that you purchased the OTC contraceptive. “Proof of loss” means a copy of the receipt that contains the Prescription information provided by the pharmacist (that is attached to the bag that contains the OTC contraceptive).

Refer to the provisions Reporting of Claims and Payment of Benefits later in this Booklet-Certificate for information on submitting claims. You can also contact Member Services by logging onto the HMO website at www.aetna.com or calling the toll-free number on the back of the ID card.

Important Note:
This Plan does not cover all over-the-counter (OTC) contraceptives. For a current listing, contact your Physician or Member Services by logging onto the HMO website at www.aetna.com or calling the toll-free number on the back of the ID card.

Voluntary Sterilization

Covered Benefits include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.

Covered Benefits under this benefit would not include 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 the confinement.

Important Reminder:
Refer to the section “Your Pharmacy Benefit” later in this Certificate for additional coverage of female contraceptives.

Benefit Limitations:
Unless specified above, not covered under this benefit are:
• Services which are covered to any extent under any other part of this Plan;
• Services and supplies incurred for an abortion;
• Services which are for the treatment of an identified illness or injury;
• Services that are not given by a Physician or under his or her direction;
• Psychiatric, psychological, personality or emotional testing or exams;
• Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA;
• Male contraceptive methods, sterilization procedures or devices; and
• The reversal of voluntary sterilization procedures, including any related follow-up care.

Primary Care Physician Benefits.

1. Office visits during office hours.
2. Home visits.
3. After-hours PCP services. PCPs must provide or arrange for on-call coverage 24 hours a day, 7 days a week. If a Member becomes sick or is injured after the PCP's regular office hours, the Member should:
   a. call the PCP's office;
b. identify himself or herself as a Member; and

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

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

4. Hospital visits.

5. Injections, including allergy desensitization injections.

6. Casts and dressings.

7. Health Education Counseling and Information.

8. Diabetic Equipment, Supplies and Education. The following equipment; supplies and education services for the treatment of diabetic conditions are covered. They must be ordered by the Member's PCP; and obtained through a Participating Provider:

   a. Insulin;
   b. Oral hypoglycemic agents;
   c. Glucose monitors;
   d. Glucose test strips;
   e. Syringes;
   f. Lancets;
   g. Coverage for diabetes outpatient self-management training and educational services that are provided through ambulatory diabetes education facilities authorized by the State’s Diabetes Control Project within the Bureau of Health.

9. Metabolic Formula and Special Modified Low-Protein Food Products. Coverage shall include metabolic formula and special low-protein food products that have been prescribed by a licensed Physician for a Member with an inborn error of metabolism. An inborn error of metabolism means: a genetically determined biochemical disorder in which a specific enzyme defect produces a metabolic block that may have pathogenic consequences at birth or later in life. A special modified low-protein food product means: food formulated to reduce the protein content to less than one gram of protein per serving and does not include foods naturally low in protein.

10. Screening for gestational diabetes.

11. Amino acid-based elemental infant formula. Covered Benefits include charges for amino acid based infant formulas for children 2 years of age and under, regardless of the method of delivery of the formula, when a Participating Provider has prescribed it.

Covered Benefits include E-Visits. You must register with an internet service. Information about Participating Providers who conduct E-Visits may be found in the provider Directory, online in DocFind on www.Aetna.com; or by calling the number on your Member identification card.
Covered Benefits also include:
- Breast reduction surgery; and
- Varicose vein surgery.
That is determined to be medically necessary.

Specialist Physician Benefits.

Covered Benefits include outpatient and inpatient services.

A Member may require ongoing care from a Specialist for a prolonged period of time for a life threatening, degenerating or disabling condition. If so, the Member may receive a standing Referral to such Specialist. A PCP in consultation with a HMO Medical Director and an appropriate Specialist may deem that a standing Referral is warranted. If so, the PCP shall make the Referral to a Specialist. This standing Referral shall be pursuant to a treatment plan approved by the HMO Medical Director in consultation with the PCP, Specialist and Member.

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

Direct Access Specialist Benefits.

These services are covered without a Referral when given by a Participating Provider.

- Routine Gynecological Examination(s). Routine gynecological visit(s) and Pap smear(s). The maximum number of visits, if any, is listed on the Schedule of Benefits.
- Direct Access to Gynecologists. Benefits are provided to female Members for services rendered 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.
- Direct Access to Participating Optometrists and Ophthalmologists for Medical Emergency. Member will be covered for up to two (2) visits; one initial and one follow-up visit; without referral from PCP.

The Optometrist or Ophthalmologist will submit a report giving the Member’s complaint; history; exam results, initial diagnosis and treatment recommendations to the Member’s PCP within three (3) working days. HMO and Member will not be liable for any services rendered if the Provider fails to submit this report within three (3) working days.

- Routine Eye Examinations, including refraction, as follows:
  1. if the Member is age 1 through 18, 1 exam(s) every 24-month period.
  2. if the Member is age 19 and over, 1 exam(s) every 24-month period.
Maternity Care and Related Newborn Care Benefits.

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

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

There is an exception to the Medically Necessary requirements of this Certificate. This coverage is provided for a mother and newly born child:

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

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

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

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

Inpatient Hospital and Skilled Nursing Facility Benefits.

A Member is covered for services only at Participating Hospitals and Participating Skilled Nursing Facilities. All services are subject to pre-authorization by HMO. If 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 deemed and told the Member that the Member no longer meets the criteria for a continued inpatient stay, 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. HMO shall not be financially responsible for such additional services.

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

Inpatient Hospital cardiac and pulmonary rehabilitation services are covered by Participating Providers. A Referral must be issued by the Member’s PCP; and pre-authorization by HMO.

Transplants Benefits.

Once it has been determined that a Member may require a Transplant, the Member or the Member’s Physician must call the Member Services number on the Member’s identification card to discuss entrance into the National Medical Excellence Program. Non-experimental or non-investigational Transplants coordinated through the National Medical Excellence Program and performed at an Institute of Excellence, (IOE), are Covered Benefits. The
IOE facility must be specifically approved and designated by HMO to perform the Transplant required by the Member.

When provided by an IOE Covered Benefits include:

- Inpatient and outpatient charges directly related to a Transplant.
- Charges for Transplant-related services. This includes pre-Transplant evaluations, testing and post-Transplant follow-up care.
- Charges made by an IOE Physician or Transplant team.
- Compatibility testing of prospective organ donors who are immediate family members.
- Charges for activating the donor search process with national registries.
- Related supplies and services provided by the IOE facility during the Transplant process. These services and supplies may include: physical; speech; and occupational therapy; bio-medicals and immunosuppressants; Home Health Services and home infusion services.

Any Copayments associated with Transplants are set forth in the Schedule of Benefits.

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

- Certain Transplant-related services or supplies including: treatment furnished to a donor when the Transplant recipient is not a Member; services and supplies not obtained from an IOE, including the harvesting of organs; bone marrow; tissue or stem cells for storage purposes; outpatient prescription drugs; and home infusion therapy.

Outpatient Surgery Benefits.

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

Substance Abuse Benefits.

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

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

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

2. Inpatient care benefits are covered for Detoxification. Benefits include medical treatment and referral services for Substance Abuse or addiction. The following services shall be covered under inpatient treatment: lodging and dietary services; Physicians; psychologist; nurse; certified addictions counselor and trained staff services; diagnostic x-ray; psychiatric, psychological and medical laboratory testing; and drugs, medicines, equipment use and supplies.
Member is entitled to medical; nursing; counseling or therapeutic Substance Abuse Rehabilitation services in an inpatient, Hospital or non-hospital Residential Treatment Facility, which is licensed by the Department of Health, upon referral by the Member’s Participating Behavioral Health Provider for alcohol or drug abuse or dependency. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.

Mental Disorders Benefits.

A Member is covered treatment of Mental Disorder through Participating Behavioral Health Providers.

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

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

Emergency Care/Urgent Care Benefits.

1. Emergency Care:

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

The Copayment for an emergency room visit as described on the Schedule of Benefits. But it 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 paid for the cost for Emergency Services rendered by a non-participating Provider located either within or outside the HMO Service Area. Payment will be made for charges, less Copayments, which are incurred up to the time the Member is deemed by HMO and the attending Physician to be medically able to travel; or to be transported to a Participating Provider. If that transportation is Medically Necessary, the Member will be paid for the cost as figured out by HMO; minus any applicable Copayments. Member might have to pay all Copayments which would have been required had similar benefits been given during office hours and upon prior Referral to a Participating Provider.

Medical transportation is covered during a Medical Emergency.
Ambulance Service

**Covered Benefits** include charges made by a professional Ambulance, as follows:

**Ground Ambulance** - charges for transportation:

- To the first Hospital where treatment is given in a medical emergency.
- From one Hospital to another Hospital in a medical emergency when the first Hospital does not have the required services or facilities to treat your condition.
- From Hospital to home or to another facility when other means of transportation would be considered unsafe due to your medical condition.
- From home to Hospital for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition. Transport is limited to 100 miles.
- When during a covered inpatient stay at a Hospital, Skilled Nursing Facility or acute rehabilitation Hospital, an Ambulance is required to safely and adequately transport you to or from inpatient or outpatient Medically Necessary treatment.

**Air or Water Ambulance** - charges for transportation to a Hospital by air or water Ambulance when:

- Ground Ambulance transportation is not available; and
- Your condition is unstable, and requires medical supervision and rapid transport; and
- In a medical emergency, transportation from one Hospital to another Hospital;
  when the first Hospital does not have the required services or facilities to treat your condition and you need to be transported to another Hospital; and the two conditions above are met.

**Urgent Care:**

**Urgent Care Within the HMO Service Area.** A Member may need 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. In that case, the Member should first seek care through the Member's PCP. If the Member’s PCP is not available within reason 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 from a Physician or licensed facility outside of the HMO Service Area. This will be covered if: the Member is temporarily absent from the HMO Service Area; and receipt of the health care service cannot be delayed until the Member returns to the HMO Service Area.

A Member is covered for any follow-up care. Follow-up care is: any care directly related to the need for Emergency Services which is furnished to a Member after the Medical Emergency or Urgent Care situation has ended. 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 to pay for all services received.
Rehabilitation Therapy.

These benefits are covered by Participating Providers upon Referral issued by the Member’s PCP and pre-authorization by HMO.

1. A limited course of cardiac rehab. An inpatient Hospital stay is covered when Medically Necessary following angioplasty; cardiovascular surgery; congestive heart failure or myocardial infarction.

2. Pulmonary rehab that follows an inpatient Hospital stay is covered when Medically Necessary. It must be for the treatment of reversible pulmonary disease states.

3. Cognitive Therapy; Physical Therapy; Occupational Therapy and Speech Therapy Rehabilitation Benefits. Coverage is subject to the limits, if any, shown on the Schedule of Benefits. For inpatient rehab; benefits for the services listed below, refer to the Inpatient Hospital and Skilled Nursing Facility benefits provision under the Covered Benefits section of this Certificate.

- Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma; stroke; or encephalopathy; and when the therapy is coordinated with HMO as part of a treatment plan intended to restore previous cognitive function.

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

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

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

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

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

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

7. Spinal Therapy Benefits - Spinal Therapy services when the services are consistent with HMO guidelines for therapeutic adjustments to and manipulation for the treatment of acute musculoskeletal conditions disorders by an HMO Participating Provider.

Home Health Benefits.

The following services are covered for a Homebound Member. They must be provided by a Participating home health care agency. Pre-authorization must be obtained from the HMO by the Member’s attending Participating Physician. HMO will not have to provide home
Health benefits when HMO deems 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 does not depend on 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. A Member may be a minor; or an adult who is dependent upon others for non-skilled care (e.g. bathing; eating; toileting). In that case, 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. But 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. But only when they are provided in conjunction with Skilled Nursing services. And they must be provided by a qualified social worker.

Outpatient home health short-term physical, speech, or occupational therapy is covered. But only 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.

Hospice Benefits.

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

Coverage is not provided for funeral arrangements; financial or legal counseling; homemaker or caretaker services; and any service not solely related to the care of the Member. This includes but is not limited to, sitter or companion services for the Member or other Members of the family. Transportation; house cleaning; and maintenance of the house are not covered.

Prosthetic Appliances Benefits.

Covered Benefits include: initial provision and replacement of a prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease or injury or congenital defects, when such device is prescribed by a Participating Provider; administered through a Participating or designated prosthetic Provider and pre-authorized by HMO. Coverage includes repair and replacement when due to congenital growth. Instruction and appropriate services required for the Member to properly use the item (such as attachment or insertion) are covered. Covered prosthetic

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appliances include those items covered by Medicare unless excluded in the Exclusions and Limitations section of this Certificate. HMO reserves the right to provide the most cost efficient and least restrictive level of service or item which can be safely and effectively provided.

Injectable Medications Benefits.

**Covered Benefits** include Injectable medications, including those medications intended to be self-administered, unless specifically excluded as set forth in the Exclusions and Limitations section of this Certificate. An oral alternative drug must not be available, 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.

If you are undergoing a course of treatment with a prescription drug as a result of a prior authorization from another Carrier, and that coverage is replaced by this coverage, Aetna will honor the prior Carrier’s authorization and will continue to provide coverage for that course of treatment in the same manner as the previous Carrier until Aetna conducts a review of the authorization with your prescriber.

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

Breast Cancer and Reconstructive Breast Surgery Benefits.

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

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

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

Hearing Aid Benefit

**Covered Benefits** for hearing care includes charges for hearing exams, prescribed hearing aids and hearing aid expenses as described below. This benefit is subject to an age limit as shown on the Schedule of Benefits.

Hearing aid means:
- Any wearable, non-disposable instrument or device designed to aid or compensate for impaired human hearing; and
- Parts, attachments or accessories.
Covered Benefits include the following:

- Charges for an audiometric hearing exam and evaluation for a hearing aid prescription performed by:
  - A Physician certified as an otolaryngologist or otologist; or
  - An audiologist who (1) is legally qualified in audiology; or (2) holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements; and who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.
- Charges for electronic hearing aids, installed in accordance with a Prescription written during a covered hearing exam;
- Any other related services necessary to access, select and adjust or fit a hearing aid.

Covered Benefits for hearing aids will not include per 36 consecutive month period:

- Charges for more than one hearing aid per ear; and
- Charges in excess of any maximum amount shown on the Schedule of Benefits.

Autism Spectrum Disorders

Covered Benefits include charges made by a physician or behavioral health provider for the services and supplies for the diagnosis and treatment, (including behavioral therapy and Applied Behavioral Analysis), of Autism Spectrum Disorder when ordered by a physician as part of a Treatment Plan; and

- The covered child is diagnosed with Autism Spectrum Disorder with onset prior to age 10.

Applied Behavioral Analysis is the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

Autism Spectrum Disorder means one of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

- Autistic Disorder;
- Rett’s Disorder;
- Childhood Disintegrative Disorder;
- Asperger's Syndrome; and
- Pervasive Developmental Disorder--Not Otherwise Specified.

Additional Benefits.

- Spinal Therapy Benefits. Spinal Therapy services when the services are consistent with HMO guidelines for therapeutic adjustments to and manipulation for the treatment of acute musculoskeletal conditions disorders by an HMO Participating Provider.
• **Diagnostic Complex Imaging Benefit**

  **Covered Benefits** include charges made on an outpatient basis by a **Physician**, **Hospital** or a licensed imaging or radiological facility for complex imaging services to diagnose an illness or injury, including:

  - C.A.T. scans;
  - Magnetic Resonance Imaging (MRI);
  - Nuclear medicine imaging, including Positron Emission Tomography (PET) Scans; and
  - Any other outpatient diagnostic imaging service costing over $500.

  Complex Imaging Expenses for preoperative testing will be payable under this benefit.

• **Outpatient Diagnostic Lab Work**

  **Covered Benefits** include charges for lab services, and pathology and other tests provided to diagnose an illness or injury. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a **Physician**. The charges must be made by a **Physician**, **Hospital** or licensed radiological facility or lab.

• **Outpatient Diagnostic Radiological Services**

  **Covered Benefits** include charges for radiological services (other than complex imaging services), provided to diagnose an illness or injury. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a **Physician**. The services must be provided by a **Physician**, **Hospital** or licensed radiological facility.

• **Outpatient Preoperative Testing**

  Prior to a scheduled covered surgery, **Covered Benefits** include charges made for tests performed by a **Hospital**, **Physician** or licensed diagnostic laboratory provided the charges for the surgery are **Covered Benefits** and the tests are:

  - Related to your surgery, and the surgery takes place in a **Hospital**;
  - Completed within 14 days before your surgery;
  - Performed on an outpatient basis;
  - Covered if you were an inpatient in a **Hospital**;
  - Not repeated in or by the **Hospital** where the surgery will be performed.
  - Test results should appear in your medical record kept by the **Hospital** where the surgery is performed.

• **Children's Early Intervention Services Benefit**

  Covered benefits include those for children's early intervention services. “Children's early intervention services”, means: services provided by licensed occupational therapists; physical therapists; speech-language pathologists or clinical social workers working with children from birth to 36 months of age with an identified developmental disability or delay as described in the federal Individuals with Disabilities Education Act, Part C, 20 United States Code, Section 1411, et seq. A referral from the child's **Primary Care Physician** is required.
• **Telemedicine Services**

Covered benefits include those for telemedicine services. Coverage shall not be denied on the basis that the coverage is provided through telemedicine if the health care service would be covered if it were provided through in-person consultation between the covered person and a health care provider. Coverage is provided for only those services that are **medically necessary**. Coverage is subject to the terms and conditions of the **Certificate** for covered health care services provided through in-person consultation.

“Telemedicine”, as it pertains to the delivery of health care services, means: the use of interactive audio; video; or other electronic media for the purpose of diagnosis; consultation; or treatment. “Telemedicine” does not include the use of audio-only telephone or facsimile machine or e-mail.

• **Clinical Trials.**

**Members** are eligible to participate in approved clinical trials in the following circumstances:

1. **Member** has a life threatening illness for which no standard treatment is effective.

2. **Member** meets the clinical trial guidelines provided by Maine State Law.

An “approved clinical trial” is a clinical trial that meets all of these criteria;
- The FDA has approved the drug, device, treatment, or procedure to be investigated or granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The clinical trial has been approved by an Institutional Review Board that will oversee the investigation;
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization. The trial conforms to the standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Coverage will be provided for items and services furnished in connection with the clinical trial, but not for the costs of tests or measurements conducted primarily for the purpose of the clinical trial or the costs of items or services reasonably expected to be paid for by the sponsors of the clinical trial.

• **Walk-in Clinic Benefit**

**Covered Benefits** include unscheduled, non-Medical Emergency **illnesses and injuries**, services and supplies provided by a Participating Walk-in Clinic.
• **Contraceptives.**

Consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of contraceptive methods.

Coverage is not provided if your employer is a religious organization who has elected not to provide coverage for contraceptive services or treatment.

• **Durable Medical Equipment Benefits.**

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

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

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

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

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

• **Infusion Therapy Benefits**

Infusion Therapy is the intravenous or continuous administration of medications or solutions that are **Medically Necessary** for the Member’s course of treatment. The following outpatient Infusion Therapy services and supplies are covered for a Member when provided by a **Participating Provider**:

- the pharmaceutical when administered in connection with Infusion Therapy; and any medical supplies, equipment; and nursing services required to support the Infusion Therapy;
- professional services;
- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives).
Not included under this infusion therapy benefit are charges incurred for:

- Blood transfusions and blood products;
- Dialysis; and
- Insulin.

Coverage is subject to the maximums, if any, shown on the Schedule of Benefits.

Inpatient infusion therapy is provided under the Inpatient Hospital & Skilled Nursing Facility Benefits section of the Covered Benefits section of the Certificate.

Coverage for Infusion Therapy benefits are only provided when rendered by Participating Providers.

Benefits payable for Infusion Therapy will not count toward any applicable Home Health Benefits maximums.

- **Chemotherapy**

  **Covered Benefits** include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient Hospitalization for chemotherapy is limited to the initial dose while Hospitalized for the diagnosis of cancer and when a Hospital stay is otherwise Medically Necessary based on your health status. This includes coverage for prescribed, orally administered anti-cancer medications used to kill or slow down the growth of cancer cells, when is equivalent to intravenous or injected anti-cancer medications.

- **Radiation Therapy Benefit**

  **Covered Benefits** include charges for the treatment of illness by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

- **Bariatric Surgery**

  **Covered Benefits** for the treatment of morbid obesity include one bariatric surgical procedure including related outpatient services, within a two-year period, beginning with the date of the first bariatric surgical procedure, unless a multi-stage procedure is planned.

  **Benefit Limitations:**

  Unless specified above, not covered under this benefit are charges incurred for:

  - Weight control services including 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 in the Certificate.

- **General Anesthesia and Associated Facility Charges for Certain Dental Procedures**

  Coverage for general anesthesia and associated facility charges apply to the following:

  - A Member or his dependents, including infants, exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to
provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result;

- A Member or his dependents demonstrate dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy;

- Extremely uncooperative, fearful, anxious or uncommunicative children or adolescents with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity; and

- A Member or his dependents have sustained extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.
EXCLUSIONS AND LIMITATIONS

Exclusions.

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

- Ambulance services, for routine transportation to receive outpatient or inpatient services.
- Beam neurologic testing.
- Biofeedback, except as pre-authorized by HMO.
- Care for conditions that state or local laws require to be treated in a public facility, including but not limited to, mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- Cosmetic Surgery, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery, other than Medically Necessary Services. This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty, except when determined to be Medically Necessary by an HMO Medical Director, is not covered. This exclusion does not apply to surgery to correct the results of injuries causing the impairment, or as a continuation of a staged reconstruction procedure including reconstruction following mastectomy, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.
- Costs for services resulting from the commission of, or attempt to commit a felony by the Member. This exclusion will not operate to deny benefits otherwise provided for treatment of an injury if the injury results from acts of domestic violence or a medical condition (including both physical and mental health conditions).
- Court ordered services, or those required by court order as a condition of parole or probation.
- Custodial Care.
- Dental services, including but not limited to, services related to the care; filling; removal or replacement of teeth and treatment of injuries to or diseases of the teeth; dental services related to the gums; apicoectomy (dental root resection); orthodontics; root canal treatment; soft tissue impactions; alveolectomy; augmentation and vestibuloplasty treatment of periodontal disease; false teeth; prosthetic restoration of dental implants; and dental implants. This exclusion does not include removal of bony impacted teeth; bone fractures; removal of tumors; and orthodontogenic cysts. In addition, subject to pre-authorization by HMO, this exclusion does not apply to anesthesia or Hospital services performed for an inpatient or outpatient dental procedure on Members;
including infants; exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia; with or without additional adjunctive techniques and modalities; cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result; Members demonstrating dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy; extremely uncooperative; fearful; anxious or uncommunicative children or adolescents with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection; loss of teeth; or other increased oral or dental morbidity; and Members who have sustained extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.

- Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, learning disabilities, or developmental delays. Special education, including lessons in sign language to instruct a Member, whose ability to speak has been lost or impaired, to function without that ability, are not covered. This exclusion does not apply to the Childrens’ Early Intervention Benefit.

- **Experimental** or **Investigational Procedures**; or ineffective surgical; medical; psychiatric; or dental treatments or procedures; research studies; or other experimental or investigational health care procedures or pharmacological regimes as determined by HMO, unless pre-authorized by HMO.

This exclusion will not apply with respect to drugs:

1. that have been granted treatment investigational new drug (IND) or Group c/treatment IND status;
2. that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or
3. **HMO** has determined that available scientific evidence demonstrates that the drug is effective or the drug shows promise of being effective for the disease.
4. in which the off-label uses are to treat cancer and HIV/AIDS.

- Hair analysis.

- Hearing aids, except as specifically set forth in the **Certificate**.

- Home births.

- Home uterine activity monitoring.
- Household equipment, including but not limited to, the purchase or rental of exercise cycles; water purifiers; hypo-allergenic pillows; mattresses or waterbeds; whirlpool or swimming pools; exercise and massage equipment, central or unit air conditioners; air purifiers; humidifiers; dehumidifiers; escalators; elevators; ramps; stair glides; emergency alert equipment; handrails; heat appliances; improvements made to a Member’s house or place of business; and adjustments made to vehicles.

- Hypnotherapy, except when pre-authorized by HMO.

- Implantable drugs, with the exception of contraceptives.

- Infertility services not explicitly covered, as provided in the Covered Benefits section of this Certificate. This exclusion includes, but is not limited to:
  1. Services for couples in which one of the partners has had a previous sterilization procedure, with or without reversal;
  2. Services for females with FSH levels greater than 19 mIU/ml on Day 3 of the menstrual cycle;
  3. The purchase of donor sperm and any charges for the storage of sperm;
  4. The purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers;
  5. Charges associated with cryopreservation or storage of cryopreserved embryos (e.g., office, Hospital, ultrasounds, laboratory tests, etc.);
  6. Artificial Insemination for females without male partners attempting to become pregnant who have not had at least 12 cycles of donor insemination (6 cycles for Members age 35 or older) prior to enrolling in HMO’s Infertility program;
  7. Any service provided by a non-participating Provider or, in the case of Comprehensive Infertility Services, without a prior Referral or claim authorization from HMO’s Infertility program case management unit;
  8. Home ovulation prediction kits;
  9. Drugs related to the treatment of non-covered benefits or related to the treatment of Infertility that are not Medically Necessary;
  10. Injectable Infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
  11. Any advanced reproductive technology (“ART”) procedures or services related to such procedures, including but not limited to in vitro fertilization (IVF); gamete intrafallopian tube transfer (GIFT); zygote intrafallopian tube transfer (ZIFT); and intracytoplasmic sperm injection (ICSI);
12. Any charges associated with care required for ART (e.g., office, Hospital, ultrasounds, laboratory tests, etc.);

13. Donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;

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

15. Reversal of sterilization surgery; and


- Military service related diseases, disabilities or injuries for which the Member is legally entitled to receive treatment at government facilities and which facilities are reasonably available to the Member.

- Missed appointment charges.

- Non-medically necessary services, including but not limited to, those services and supplies:

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

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

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

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

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

- Orthotics.

- Outpatient supplies, including but not limited to; medical consumable or disposable supplies such as syringes; incontinence pads; elastic stockings; and reagent strips.

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

- Personal comfort or convenience items; including those services and supplies not directly related to medical care; such as guest meals and accommodations; barber services; telephone charges; radio and television rentals; homemaker services; travel expenses; take-home supplies; and other like items and services.
• Prescription or non-prescription drugs and medicines, except as provided on an inpatient basis.

• Private duty or special nursing (see the Home Health Care Benefits section regarding coverage of nursing services).

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

• Religious counseling; sex counseling; including sex therapy.

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

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

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

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

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

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

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

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

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

• 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), except as provided in the exceptions to the exclusion for Experimental or Investigational Procedures;
2. needles; syringes and other injectable aids; except for diabetic supplies as listed in the Covered Benefits section;

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.

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

- Thermograms and thermography.

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

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

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

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

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

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

- Acupuncture and acupuncture therapy, except as set forth in this Certificate.
• Services related to the care, filling, removal or replacement of impacted teeth.

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

Limitations.

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

• Determinations regarding eligibility for benefits, coverage for services, benefit denials and all other terms of this Certificate are subject to the terms of this Certificate.

DETERMINATIONS REGARDING DENIAL OF BENEFITS DUE TO INAPPROPRIATE USE OF THE HMO NETWORK ARE MADE BY 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.

NOTE: will notify the Member, or a person designated by the Member, prior to cancellation of this Certificate for non-payment of premiums.

A. Termination of Subscriber Coverage.

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

1. employment ends;
2. the Group Agreement ends;
3. the Subscriber is no longer eligible as outlined in this Certificate and/or on the Schedule of Benefits; or
4. the Subscriber becomes covered under another 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 end if:

1. a Covered Dependent is no longer eligible, as set forth in this Certificate and/or on the Schedule of Benefits;
2. the Group Agreement ends; or
3. the Subscriber’s coverage ends

C. Termination For Cause.

HMO may end coverage for cause:

1. upon 31 days advance written notice, if the Member has failed to make any required Copayment or any other payment which the Member has to pay. Upon the effective date of the end of coverage, prepayments received by HMO on account of such terminated Member or Members for periods after the effective date coverage ends shall be refunded to Contract Holder.
2. Right away, if it discovers an intentional material misrepresentation by a Member that applies for or obtains coverage or benefits under this Certificate; or upon discovery of the Member’s commission of fraud against HMO. This may include, but is not limited to, furnishing incorrect or misleading information to HMO; or allowing or assisting a person other than the Member named on the identification card to obtain HMO benefits. HMO may, 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 charge; and reasonable attorneys’ fees. If there is no fraud or material misrepresentation, anything state
by any Member or any person that applies 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 end 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 the end of coverage.

A Member may ask that HMO conduct a grievance hearing within 15 working days after receiving notice that HMO has or will end the Member's coverage as set forth 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 given, 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 ended had the Member not asked 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 it ends, minus the cost of Covered Benefits provided to a Member during this period.

Coverage will not be ended on the basis of a Member's health status or health care needs, It will not end if a Member has exercised the Member's rights under the Certificate’s Grievance Procedure to make a complaint against HMO. The grievance process described in the preceding paragraph applies only when coverage endings are affected by the Termination For Cause subsection of this Certificate.

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

The fact that Members are not told by the Contract Holder that their coverage has ended due to the ending of the Group Agreement shall not extend the Members' coverage after the date coverage ends.

CONTINUATION AND CONVERSION

A. COBRA Continuation Coverage.

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

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 coverage ending (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. Covered Dependent child status ceases under the Eligibility and Enrollment section of this Certificate:

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

4. Continuation coverage ends at the earliest of the following events:
   a. the last day of the 18 month period.
   b. the last day of the 36 month period.
   c. the first day on which timely payment of Premium is not made subject to the Premiums section of the Group Agreement.
   d. the first day on which the Contract Holder ceases to maintain any group health plan.
   e. the first day, after the day COBRA coverage has been elected, on which a Member is actually covered by any other group health plan. In the event the Member has a preexisting condition, and the Member would be denied coverage under the new plan for a preexisting condition, continuation coverage: will not be terminated until the last day of the continuation period; or the date upon which the Member's preexisting condition becomes covered under the new plan, whichever occurs first.
   f. the date, after COBRA coverage has been elected, when the Member is entitled to Medicare.

5. Extensions of Coverage Periods:
   a. The 18 month coverage period may be extended if an event which would otherwise qualify the Member for the 36 month coverage period occurs during the 18 month period. 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 tells the Contract Holder within 60 days of the Social Security determination and before the end of the initial 18 month period, continuation coverage for the Member and other qualified beneficiaries may be extended up to an additional 11 months for a total of 29 months. The Member must have become disabled during the first 60 days of the COBRA continuation coverage.
6. Responsibility of the Contract Holder to provide Member with notice of Continuation Rights:

The Contract Holder is responsible for giving the needed notice to Members, within the defined time period, as required by COBRA.

7. Responsibility to pay Premiums to HMO:

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

8. Premiums due HMO for the continuation of coverage under this section shall be due as set forth in the procedures of the Premiums section of the Group Agreement. Premium shall be calculated as set forth in the federal law and regulations that apply.

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

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

1. the date of discharge from such inpatient stay;
2. determination by the HMO Medical Director in consultation with the attending Physician, that care in the Hospital or Skilled Nursing Facility is no longer Medically Necessary;
3. the date the benefit limit in the contract has been reached;
4. the date the Member becomes covered for similar coverage from another health benefits plan; or
5. 12 months of coverage under this extension of benefits provision.

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

C. Conversion Privilege.

This subsection does not extend the coverage under the Group Agreement. It permits HMO to issue an individual health care coverage agreement (conversion coverage) under some conditions.

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

1. Eligibility.
In the event: a **Member** stops being eligible for coverage under this **Certificate**; and has been continuously enrolled for 3 months under **HMO**; such person may, within 31 days after coverage ends under this **Certificate**, convert to individual coverage with **HMO**. The effective date will be as of the date such coverage ends, without evidence of good health as long as that **Member**’s coverage under this **Certificate** ended for 1 of these reasons:

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

b. the **Subscriber** no longer meets the eligibility requirements as described in this **Certificate** and on the Schedule of Benefits, in which case the **Subscriber** and **Subscriber**’s dependents who are **Members** pursuant to this **Certificate**, if any, are eligible to convert;

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

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

Any **Member** who is eligible to convert to individual coverage, may do so as set forth in the rules and regulations that govern items such as first payment, the form of the agreement and all terms and conditions as **HMO** may have in effect at the time of **Member**’s application for conversion. No evidence of good health is needed. The conversion coverage will provide benefits no less than what is then required by, and no benefits contrary to, any law or regulation that applies. But, the conversion coverage may not provide the same coverage. Coverage 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**. A **Covered Dependent** child has the right to convert upon reaching the age limit on the Schedule of Benefits or upon death of the **Subscriber** (subject to the ability of minors to be bound by contract).

**CLAIM PROCEDURES**

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**; 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 sent 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. In certain cases, these time frames may be extended. If **HMO** makes an **adverse benefit determination**, notice will be provided in writing to the **Member**. In the case of a concurrent care claim, notice will be given 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 the ending of a benefit or the amount paid for it. It also means a decision not to provide a benefit or service or end 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 limits 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. If a Provider or Member will not release clinically relevant, necessary information for review, HMO may deny certification of the services.

A “final adverse benefit determination” is an adverse benefit determination that has been upheld by HMO at the exhaustion of the appeals process.
<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Response Time from Receipt of Claim</th>
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<tr>
<td><strong>Urgent Care Claim.</strong> 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.</td>
<td>As soon as possible. But not later than 24 hours after the claim is made. If more information is needed to make an Urgent Care Claim decision, HMO will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide HMO with the additional information. HMO will notify the claimant within 48 hours of the earlier to occur: • the receipt of the additional information; or • the end of the 48 hour period given the Physician to provide HMO with the information.</td>
</tr>
<tr>
<td><strong>Pre-Service Claim.</strong> A claim for a benefit that requires pre-authorization of the benefit in advance of obtaining medical care.</td>
<td>Within 2 working days after obtaining all needed information. HMO will not later render an adverse decision with respect to any pre-authorized services except if fraudulent or materially incorrect information was provided at the time the services were pre-authorized, and such information was used in pre-authorizing the services.</td>
</tr>
<tr>
<td><strong>Concurrent Care Claim Extension.</strong> A request to extend a course of treatment previously pre-authorized by HMO.</td>
<td>Within one working day of obtaining all needed information.</td>
</tr>
<tr>
<td><strong>Concurrent Care Claim Reduction or Termination.</strong> Decision to reduce or end a course of treatment previously pre-authorized by HMO.</td>
<td>Within one working day of obtaining all necessary information. If the Member files an Appeal, Covered Benefits under the Certificate will continue for the previously approved course of treatment until a final Appeal decision is rendered. During this continuation period, the Member is responsible for any Copayments and Deductibles that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under Appeal. If HMO’s initial claim decision is upheld in the final Appeal decision, the Member will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.</td>
</tr>
<tr>
<td><strong>Retrospective Claim.</strong> A claim for a benefit that is not a pre-service claim.</td>
<td>Within 30 calendar days of obtaining all needed information.</td>
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</table>

**Requests for Reconsideration of an Adverse Utilization Review Determination.** For an initial or concurrent review determination, the Provider rendering the service can request, by telephone, fax or in writing, a reconsideration on behalf of the Member. The reconsideration will occur within one (1) working day of the receipt of the request. It will be conducted between the Provider rendering the service and the reviewer who made the
adverse determination; or a qualified health care professional designated by the reviewer, if the reviewer cannot be available within one (1) working day. The reconsideration process may not resolve the difference of opinion. In that case, the adverse determination may be appealed by the Member or by the Provider on the Member’s behalf. A reconsideration is not required before appealing an adverse determination.
COMPLAINTS AND APPEALS

HMO has procedures for Members to use if they are not satisfied with a decision that the HMO has made or with the operation of the HMO. The procedure the Member needs to follow will depend on the type of issue or problem the Member has.

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

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

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

A. **Complaints.**

A Member may not satisfied with the administrative services the Member receives from the HMO or wants to complain about a Participating Provider. In that case, the Member needs to, 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. The response will be provided within a reasonable timeframe 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 within a reasonable timeframe from the date of the notice. Except for Urgent Care Claims, an acknowledgement letter will be sent to you within three (3) working days of HMO's receipt of the appeal. The letter will contain the name; address; and telephone number of the Appeal Coordinator assigned to
review the appeal. If the appeal concerns medical necessity; appropriateness; health care setting; level of care; or effectiveness the Coordinator will be a clinical peer health care professional. If the letter requests additional information, it must be sent to HMO within the next 15 days.

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. But, 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 levels 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). Note: The Member may waive the second level Appeal and request instead an External Review. If the Member decides to Appeal to the second level, the request must be made in writing within a reasonable timeframe from the date of the notice. The following chart provides a summary of some information about how the Appeals are handled for different types of claims.

A level two Appeal of a decision involving an Urgent Care Claim, or a claim involving medical necessity; appropriateness; health care setting; level of care; or effectiveness; shall be provided by the HMO Appeals Committee. The majority of the Committee will be made up of persons not previously involved in the Appeal. But, a person who was previously involved in the Appeal may be a member of the Committee. Such person may also appear before the Committee to present information or answer questions. The Committee must one or more clinical peer health care professionals who were not previously involved in the Appeal, who are not a subordinate of a person involved in the Appeal, and who have no financial or other personal interest in the outcome of the review. The level two Appeal decision must have the agreement of the majority of such clinical peer health care professionals.

For a level two Appeal that deals with all other appeals, the majority of the Committee will be made up of employees or representatives of HMO who were not previously involved with the Appeal. But, a person who was previously involved in the Appeal may be a member of the Committee. The person may also appear before the Committee to present information or answer questions.

If you ask to appear in person before the Committee, the Committee will notify you in writing 15 days in advance of the hearing date. The notice will also advise you if an attorney will be present to argue HMO’s case against you. HMO will also advise you of your right to obtain legal representation. The hearing will be held during regular business hours. If you cannot attend the hearing, you may participate by conference call; or other available technology; at HMO’s expense. You may also request that HMO consider a postponement and rescheduling of the hearing. In addition:

- You may request HMO to provide you with all relevant information that is not confidential or privileged.
- You may be helped or represented at the hearing by the person of your choice.
- You may submit supporting material. This may be done both before and during the hearing.
- You may ask questions of any HMO representative.
<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Level One Appeal HMO Response Time from Receipt of Appeal</th>
<th>Level Two Appeal HMO Response Time from Receipt of Appeal</th>
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<tbody>
<tr>
<td><strong>Urgent Care Claim</strong>. 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.</td>
<td>Within 36 hours Review provided by HMO personnel not involved in making the adverse benefit determination.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Pre-Service Claim</strong>. A claim for a benefit that requires approval of the benefit in advance of obtaining medical care.</td>
<td>Within 15 calendar days or receipt of any additional information requested. Review provided by HMO personnel not involved in making the adverse benefit determination.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Concurrent Care Claim Extension</strong>. A request to extend or a decision to reduce a previously approved course of treatment.</td>
<td>Within one working day of obtaining all needed information.</td>
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</tr>
<tr>
<td><strong>Concurrent Care Claim Reduction or Termination</strong>. Decision to reduce or terminate a course of treatment previously pre-authorized by HMO.</td>
<td>Within one working day of obtaining all needed information.</td>
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</tr>
<tr>
<td><strong>Retrospective Claim</strong>. Any claim for a benefit that is not a pre-service claim.</td>
<td>Within 30 calendar days or receipt of any additional information requested. Aetna will notify you in writing within 5 working days after making the determination. Review provided by HMO personnel not involved in making the adverse benefit determination.</td>
<td>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.</td>
</tr>
</tbody>
</table>
A Member and/or an authorized representative may attend the Level Two Appeal hearing. They may 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.

If HMO's final decision is an adverse decision, it will contain:

- The names; titles; and qualifying credentials of the person(s) involved in the review;
- A statement of the Coordinator's understanding of the Appeal; and all pertinent facts;
- The specific plan provisions upon which the decision is based.
- The Coordinator's basis for the decision in clear terms;
- A reference to the evidence; or documentation; used as the basis for the decision; and instructions for requesting copies of such materials;
- A notice of your right to contact the Maine Bureau of Insurance, including the address and telephone number of the Bureau;
- A description of the process to obtain a level two Appeal (including the rights; procedures; and time frames that govern such an appeal).
- The availability of any applicable office of health insurance consumer assistance or ombudsman established under the federal Affordable Care Act;
- Notice of the right to file a complaint with the Bureau of Insurance after exhausting any appeals under a carrier's internal review process;
- Any other information required pursuant to the federal Affordable Care Act.

D. Exhaustion of Process.

The foregoing procedures and process are mandatory and must be exhausted prior to the starting 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.

In certain cases, 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 adverse benefit determination and Appeal requirements (including required timeframes for issuing decisions) of the state of Maine and 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.

Maine Bureau of Insurance Assistance

The Member or his or her designated representative has the right to contact the Maine Bureau of Insurance for assistance at any time. The address is:

Department of Professional and Financial Regulation
Bureau of Insurance
34 State House Station
Augusta, ME 04333-0034

The consumer toll free number is 1-800-300-5000.
EXTERNAL REVIEW

Under certain circumstances, the Member, or the Member’s representative, has the right to an external review of a denial of coverage. Specifically, if HMO has denied coverage on the basis that the service is not Medically Necessary, a pre-existing condition exclusion, or is an experimental or investigational treatment.

1. The Member must file a written request for external review with the Superintendent of Insurance within 12 months from the date the Member receives a final adverse health care treatment decision under HMO’s Complaints and Appeals section.

2. Prior to requesting an external review the Member must either:
   a. exhaust the first and second levels of the Complaint and Appeal section; or
   b. meet the criteria for expedited review.

3. HMO must advise the Member on notices of adverse health care treatment that expedited external review is available:
   a. if HMO has failed to issue a written decision on an internal appeal or grievance within the required time periods, and the delay is the fault of HMO;
   b. HMO and Member mutually agree in writing to bypass the internal Complaint and Appeal procedures;
   c. Member has a medical condition where the timeframe for the HMO’s internal Complaint and Appeal section could result in serious jeopardy to the life or health of the Member, or could jeopardize the Member’s ability to regain maximum function;
   d. A Member’s representative may request an expedited external review if the Member has died.

4. A written Notice of Decision is due within 30 days from the date the external review entity receives the case from the Maine Bureau of Insurance, unless the Member requests and is granted an expedited review. A decision on a request for an expedited review must be made by the expedited review entity within 72 hours of receipt of a completed request for an expedited review.

5. Member and/or the Member’s representative has the right to:
   a. attend the external review;
   b. submit and obtain supporting materials relating to the adverse health care treatment under review;
   c. ask questions of any representative of HMO and have outside assistance.

6. HMO must provide, within 5 days of the notification by the Maine Bureau of Insurance that an external review has been requested, copies of the following to the Bureau if in possession of HMO or available to HMO from a Participating Provider:
   a. copies of all medical records, clinical criteria and other records considered by HMO in reaching its adverse health care treatment decision;
   b. Member may request a copy of the transcript of any appeal hearing be included in the record for external review, if such transcript has been made by HMO;
c. all relevant clinical information relating to the Member’s physical and mental condition;

d. recommendation of the attending Provider;

e. terms of coverage under the Member’s health plan with HMO;

f. all clinical standards and guidelines relied upon by HMO or HMO’s Claim Procedure/Complaint and Review entity in rendering the health care treatment decision under review; and

g. all other documents pertaining to the health care treatment under review.

7. HMO must provide any additional information requested by the external review entity, Maine Bureau of Insurance, Member or Member’s representative. Requests may be made by telephone, in writing, via facsimile or by e-mail. Additional information, documents or records requested from HMO must be provided within 5 days unless an extension is requested and granted by the Maine Bureau of Insurance. In the case of an expedited review, HMO must provide the requested information as expeditiously as the Member’s condition requires.

8. If HMO wishes to exercise its right to attend the external review hearing, HMO must give written notification to the external review entity, Maine Bureau of Insurance, Member and/or Member’s representative within 5 days of notification of the request for external review by the Maine Bureau of Insurance.

9. HMO is required to pay for the cost of the external review.

10. HMO will provide auxiliary telecommunications devices or qualified interpreter services by a person proficient in American Sign Language when requested by a Member who is deaf or hard-of-hearing or printed materials in an accessible format, including Braille, large-print materials, computer diskette, audio cassette or a reader when requested by an Member who is visually impaired to allow the Member to exercise their rights to an external review.

11. External review decision is binding on HMO. A Member and/or Member’s representative may not file a request for a subsequent external review involving the same adverse health care treatment decision for which the Member and/or Member’s representative has already received an external review decision.
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.
COORDINATION OF BENEFITS

Some Members have health coverage other than 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. It may include a applicable benefits payable for dental or pharmacy services or supplies.

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

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

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

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

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

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

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

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

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

2. is secondary to Medicare.

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

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

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

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

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

3. If there is not such a court decree:

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

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

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

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

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

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

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

If the other plan does not have a provision:

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

then the above paragraph will not apply.

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

If the other plan does not have a provision:

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

then the above paragraph will not apply.

H. If the preceding rules do not determine the primary plan, the **Covered Benefits** shall be shared equally between the plans meeting the definition of plan under this section. In addition, this plan will not pay more than it would have paid had it been primary.
HMO has the right to release or obtain any information and make or recover any payment it considers needed in order to administer this provision.

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

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

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

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

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

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

The coverage under this Certificate will not duplicate any benefits for which Members are, or could be, eligible for: under any other federal or state government programs (such as Workers' Compensation). All sums payable under such programs for services provided under this Certificate shall be payable to and kept 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 ended coverage under a program; or
4. Have failed to ask for coverage under a program.

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

Covered Persons Who Are Disabled or Who Have End Stage Renal Disease (ESRD). Special rules apply to Members who are disabled or who have End Stage Renal Disease. This Certificate will make primary and secondary payer determination as set forth in the Omnibus Budget Reconciliation Act (OBRA), as amended.

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

SUBROGATION AND RIGHT OF RECOVERY

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

The Member specifically acknowledges HMO’s right of subrogation in writing. When HMO provides health care benefits for injuries or illnesses for which another party is or may be
responsible, HMO shall be subrogated to the Member’s rights of recovery. The subrogation will be on a fair and equitable basis against any party to the extent of the full cost of all benefits provided by HMO. HMO may act against any party with or without the Member’s consent.

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

For the basis of these subrogation and reimbursement provisions, a just and equitable basis shall be defined as any factors that diminish the potential value of the Member’s claim.

These factors that may diminish the potential value of the Member’s claim shall include, but are not limited to the following:

1. legal defenses;
2. exigencies of trial; and/or
3. limits of coverage.

The Member and the Member’s representatives further agree to tell HMO promptly and in writing: (a) when notice is given to any party of the intention to investigate or pursue a claim to recover damages; or (b) obtain compensation due to injuries or illness sustained by the Member that may be the legal responsibility of another party.

If the Member agrees, in writing, for HMO to exercise its subrogation and right of reimbursement rights, Member and the Member’s representative agree to:

A. Cooperate with HMO and do what is needed to secure HMO’s rights of subrogation and/or reimbursement under this Certificate;
B. Give HMO a lien on any recovery; settlement; or judgment or other source of compensation which may be had from any party. This will be done to the extent of the full cost of all benefits associated with injuries or illness provided by HMO for which another party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement);
C. Pay from any recovery; settlement; or judgment or other source of compensation, any and all amounts due HMO as reimbursement for the full cost of all benefits associated with injuries or illness provided by HMO for which another party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by HMO in writing; and
D. Do nothing to prejudice HMO’s rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by HMO.
RECOVERY RIGHTS RELATED TO WORKERS' COMPENSATION

If benefits are provided by HMO for Illness or Injuries to a Member and HMO determines the Member received Workers' Compensation benefits for the same incident that resulted in the illness or injuries, HMO has the right to recover as described below. “Workers’ Compensation benefits” includes benefits paid in connection with a Workers’ Compensation claim, whether paid by an employer directly, a Workers’ Compensation insurance carrier, or any fund designed to provide compensation for Workers’ Compensation claims.

The Recovery Rights will be applied as follows:

For Compensable Claims:

a) The HMO may exercise its Recovery Rights against the provider in the event that the work-related injury is deemed compensable either by the Workers’ Compensation carrier; an order of the Maine Workers’ Compensation Board approving a settlement agreement; or by a final adjudication of the claim pursuant to Maine Workers’ Compensation laws. In such case, the HMO may request that the provider rebill the Workers’ Compensation carrier for medical treatment given as a result of the compensable sickness or injury; or

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

c) The HMO may exercise its Recovery Rights directly against the Workers’ Compensation carrier in an amount equal to the total benefits paid by the HMO for compensable work-related sickness or injury.

For Claims Paid by Means of Settlement or Compromise:

d) The HMO may exercise its Recovery Rights against the Member when the disputed claim is paid in a lump sum by means of settlement or compromise; or

e) The HMO may exercise its Recovery Rights against the Workers’ Compensation carrier when the claim in dispute is paid in a lump sum; by means of settlement or compromise; in an amount equal to the total benefits paid by the HMO.

By accepting benefits under this Plan, the Member and the Member’s representatives further agree to:

A. Comply with 02-031 Code of Maine Rules Chapter 530 Section 4 by pursuing any disputed claim against an employer/Workers’ Compensation carrier through the mediation level established pursuant to 39A M.R.S.A. 153(6).

B. Tell HMO promptly and in writing when notice is given to any party of the intention to: investigate or pursue a claim to recover damages; or obtain compensation due to work-related illness or injuries sustained by the Member;

C. Cooperate with HMO, provide HMO with requested information, and do whatever is necessary to secure HMO’s Recovery Rights under this Certificate;

D. Pay from any recovery, settlement, judgment, or other source of compensation, any and all amounts due HMO as reimbursement for the full cost of all benefits associated with work-related illness or injuries provided by this Plan;
E. Do nothing to prejudice HMO's rights as set forth above. This includes, but is not limited to, not making any settlement or recovery which attempts to reduce or exclude the full cost of all benefits paid by this Plan.

For those cases deemed compensable by a workers’ compensation carrier or by the Workers’ Compensation Board, no court costs or attorney fees may be deducted from HMO’s recovery. HMO is not required to pay or contribute to paying court costs or attorney’s fees for the attorney hired by the Member to pursue the Member’s claim or lawsuit against any Responsible Party without the prior written consent of HMO. But, in those cases that resulted in a negotiated settlement, consideration would be given to a fair and equitable reduction for attorney fees. In the event the Member or the Member’s representative fails to cooperate with HMO, the Member shall be responsible for all benefits provided by this plan in addition to costs and attorney’s fees incurred by HMO in obtaining payment.

RESPONSIBILITY OF MEMBERS

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

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

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

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

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

A. **Identification Card.** The identification card issued by HMO to Members under this Certificate is for identification purposes only. Having an HMO identification card confers no right to services or benefits under this Certificate. Misuse of such card may be grounds to end Member’s coverage under the Termination of Coverage section of this Certificate. If the Member who misuses the card is 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 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 kept by HMO. All rights of such Member and their Covered Dependents, if any, under this Certificate shall end immediately. But is subject to the Grievance Procedure.

B. **Reports and Records.** HMO is has the right to receive from any Provider of services to Members, information reasonably needed to administer this Certificate. This is subject to all confidentiality requirements that may apply, as defined in the General Provisions section. 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. give reports on 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) thinks 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 given condition. This decision is subject to the Grievance Procedure in this Certificate. Coverage for treatment of the condition involved will be resumed in the event Member agrees to follow the recommended treatment or procedure.

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

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

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

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

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

4. HMO cannot guarantee that any Provider or facility will continue with HMO. In the event a PCP ends its contract; or is terminated by HMO; HMO shall give notice to Members as follows:

   a. within 30 days of the end of a PCP contract to each affected Subscriber, if the Subscriber or any Dependent of the Subscriber is then enrolled in the PCP’s office; and

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

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

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

H. Confidentiality. Information contained in the medical records of Members and information received from any Provider incident to the provider-patient relationship shall be kept confidential. This is in accordance with the law that applies. Information may be used or disclosed by HMO when needed for a Member’s care or treatment; the operation of HMO and administration of this Certificate; or other activities, as permitted by any law that applies. For other purposes, information may be disclosed only with the consent of the Member. Members can obtain a copy of HMO’s Notice of Information Practices by calling the Member Services toll-free phone number listed on the Member’s identification card.
I. **Limitation on Services.** Except in cases of **Emergency Services** or **Urgent Care**, or as may be provided under 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 deemed representations and not warranties. 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**. But, this **Certificate** shall be subject to amendment; modification; or termination by operation of law; by filing with and approval by the Maine Bureau of Insurance. This can also be done by mutual written agreement between **HMO** and **Contract Holder**. It may be done 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 taking any information. No change in this **Certificate** shall be valid unless evidenced by an endorsement to it signed by an authorized representative of **HMO**.

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

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

Q. From time to time **HMO** may offer or provide **Members** access to discounts on health care related goods or services. While **HMO** has arranged for access to these goods, services and/or third party provider discounts, the third party service providers are liable to the **Members** for the provision of such goods and/or services. **HMO** is not responsible for the provision of such goods and/or services nor is it liable for the failure of the provision of the same. Further, **HMO** is not liable to the **Members** for the negligent provision of such goods and/or services by third party service providers. These discounts are subject to modification or discontinuance without notice.
Proof of Loss and Claims Payment
The following provisions apply only as they relate to breast pump services and supplies obtained from a Non-Participating Provider and contraceptives obtained from a pharmacy under the Preventive Care Benefit. For more information refer to the Preventive Care Benefit earlier in this amendment.

- **Proof of Loss:** Written proof of loss must be furnished to HMO within 90 days after a Member incurs expenses for Covered Benefits. Failure to furnish the proof of loss within the time required will not invalidate nor reduce any claim. But this is true only if it is not reasonably possible to give the proof of loss within 90 days, provided the proof of loss is furnished as soon as reasonably possible. But, except in the absence of legal capacity of the claimant, the proof of loss may not be furnished later than one year from the date when the proof of loss was originally required. A proof of loss form may be obtained from HMO or the Contract Holder. If the Member does not receive such form before the expiration of 15 working days after HMO receives the request, the Member shall be deemed to have complied with the requirements of this Certificate upon submitting within the time fixed in this Certificate written proof covering the occurrence, character and extent of the loss for which claim is made.

- **Time for Payment of Claim:** Benefits payable under this Certificate will be paid promptly after the receipt by HMO of satisfactory proof of loss. If any portion of a claim is contested by HMO, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss by HMO.
DEFINITIONS

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

- **Autism Spectrum Disorder**: This means one of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:
  - (a) Autistic Disorder;
  - (b) Rett’s Disorder;
  - (c) Childhood Disintegrative Disorder;
  - (d) Asperger's Syndrome; and
  - (e) Pervasive Developmental Disorder--Not Otherwise Specified.

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

- **Biosimilar Prescription Drug(s)**. A biological Prescription Drug that is highly similar to a U.S. Food and Drug Administration (FDA) – licensed reference biological Prescription Drug notwithstanding minor differences in clinically inactive components, and for which there are no clinically meaningful differences between the highly similar biological Prescription Drug and the reference biological Prescription Drug in terms of the safety, purity, and potency of the drug. As defined in accordance with U.S. Food and Drug Administration (FDA) regulations.

- **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 Aetna.

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

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

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

- **Coinsurance**. The part of the cost of services and supplies for Covered Benefits which a Member must pay for care, after first meeting any applicable Deductible amount. A Member does not have to pay Coinsurance after the Member reaches the Individual and Family Maximum Out-of-Pocket Limits, if any, as listed on the Schedule of Benefits.
- **Contracted Rate(s).** The **Contracted Rate** is the amount that a **Participating Provider** has agreed to accept as payment in full for any service or supply for the purpose of the **Covered Benefits** under this plan. As used within the **HMO** agreement, including the **HMO Certificate**, Schedule of Benefits; riders and amendments; any references to "contracted charge(s)", "negotiated fee(s)" or "negotiated rate(s)" mean "Contracted Rates".

- **Designated Participating Providers.** These are **Participating Providers** that are shown in the **Directory** and in DocFind® as **Choose and Save**, **Savings Plus**, or **ACO** providers for the class of employees of which the **Subscriber** is a member. Coverage for these **Designated Participating Providers** is provided through the **Certificate** forms that are issued by **HMO**.

- **Directory.** A listing of **Participating Providers** serving the class of employees to which a **Subscriber** belongs. The **Contract Holders** may give **Subscribers** a copy of a printed **Directory** upon request. **Unless otherwise noted in this rider, Participating Provider information is available through HMO’s printed Directory and the on-line Directory, DocFind®.**

- **Non-Designated Participating Providers.** These are **Participating Providers** that are shown in the **Directory** and in DocFind® but not as **Choose and Save** or **Savings Plus** providers for the class of employees of which a **Subscriber** is a member. Coverage for these **Non-Designated Participating Providers** is provided through the **Certificate** forms that are issued by **HMO**.

- **Self-Referral, Self-Referred.** The process whereby a **Member** receives **Covered Benefits** from **Participating Providers** (designated and non-designated) without obtaining a prior **Referral** from the **HMO Primary Care Physician**

- **Coordination of Benefits.** A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by 2 or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing the authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first. Refer to the Coordination of Benefits section of this **Certificate** for a description of the **Coordination of Benefits** provision.

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

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

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

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

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

- **Creditable Coverage.** Coverage of the Member under a group health plan (including a governmental or church plan); a health insurance coverage (either group or individual insurance); Medicare; Medicaid; a military-sponsored health care (CHAMPUS); a program of the Indian Health Service; a State health benefits risk pool; the Federal Employees Health Benefits Program (FEHBP); a public health plan, and any health benefit plan under section 5(e) of the Peace Corps Act 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.

- **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.

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

- **Durable Medical Equipment (DME).** Equipment, as determined by HMO, which is a) made for and mainly used in the treatment of a disease or injury; b) made to withstand prolonged use; c) suited for use while not confined as an inpatient in the Hospital; d) not
normally of use to persons who do not have a disease or injury; e) not for use in altering air quality or temperature; and f) not for exercise or training.

- **Effective Date of Coverage.** The date in which coverage starts under this Certificate, as shown on the records of HMO.

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

- **Experimental or Investigational Procedures.** Services or supplies that are, as determined by HMO, experimental. A drug, device, procedure or treatment will be determined to be experimental if:
  1. there is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
  2. required FDA approval has not been granted for marketing; or
  3. a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or
  4. the written protocol or protocol(s) used by the treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or
  5. it is not of proven benefit for the specific diagnosis or treatment of a Member’s particular condition; or
  6. it is not generally recognized by the Medical Community as effective or appropriate for the specific diagnosis or treatment of a Member’s particular condition; or
  7. it is provided or performed in special settings for research purposes.

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

- **Habilitation.** Health services that help a person keep, learn or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

- **Health Maintenance Organization (HMO).** Aetna Health Inc., a Maine corporation licensed by Maine Bureau of Insurance as a Health Maintenance Organization.
- **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.

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

- **Hospice Care.** A program of care that is provided by a **Hospital**, **Skilled Nursing Facility**, hospice, or a duly licensed **Hospice Care** agency, and is approved by **HMO**, and is focused on a palliative rather than curative treatment for **Members** who have a medical condition and a prognosis of less than 12 months to live. **Hospice Care** service includes, but is not limited to: **Physician** services; nursing care; respite care; medical and social work services; counseling services; nutritional counseling; pain and symptom management; medical supplies and durable medical equipment; occupational, physical or speech therapies; volunteer services; **Home Health** care services; and bereavement services.

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

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

- **Institute of Excellence**\(^\text{TM}\) (IOE). One of a network of facilities within the **National Medical Excellence Program**\(^*\) specifically contracted with by **HMO** to provide certain **Transplants** to **Members**. A facility is considered a **Participating Provider** only for those types of **Transplants** for which it has been specifically contracted.

- **National Medical Excellence Program.** Coordinating **HMO** services team for **Transplant** services and other specialized care.

- **Transplant.** Replacement of solid organs; stem cells; bone marrow or tissue. Includes related services such as pre-procedure evaluations, testing and follow-up care.

- **Traveling Companion.** A person whose presence as a companion or caregiver is necessary to enable a **Member** to receive services in connection with a **Transplant** on an inpatient or outpatient basis; or to travel to and from the **IOE** facility where treatment is provided.
• **Interested Parties** means **Contract Holder** and **Members**; including any and all affiliates; agents; assigns; employees; heirs; personal representatives or subcontractors of an **Interested Party**.

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

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

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

• **Medically Necessary, Medically Necessary Services, or Medical Necessity**

  Means health care services or products provided to a Member for the purpose of preventing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is:

  A. Consistent with generally accepted standards of medical practice;
  B. Clinically appropriate in terms of type, frequency, extent, site and duration;
  C. Demonstrated through scientific evidence to be effective in improving health outcomes;
  D. Representative of “best practices” in the medical profession; and
  E. Not primarily for the convenience of the Member or Physician or other health care practitioner.

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

• **Morbid obesity,** A Body Mass Index that is: greater than 40 kilograms per meter squared; or equal to or greater that 35 kilograms per meter squared with a high risk comorbid medical condition, including significant cardiovascular disease, sleep apnea or uncontrolled type-2 diabetes.

• **Mental Disorder.** An illness commonly understood to be a **mental disorder**, whether or not it has a physiological or organic basis, and for which treatment is generally provided by or under the direction of a **behavioral health provider** such as a psychiatrist a psychologist or a psychiatric social worker.

The following conditions are considered a mental disorder:

• Anorexia/bulimia Nervosa.
• Bipolar disorder
• Major depressive disorder
• Obsessive compulsive disorder
• Panic disorder
• Pervasive Mental Developmental Disorder (including Autism)
• Psychotic Disorders/Delusional Disorders
• Schizo-affective Disorder
• Schizophrenia
• **Non-Hospital Facility.** A facility, licensed by the appropriate regulatory authority, for the care or treatment of alcohol or drug dependent persons, except for transitional living facilities.

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

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

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

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

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

  • Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
  • Provides medical services which are within the scope of his or her license or certificate;
  • Under applicable insurance law is considered a "physician" for purposes of this coverage;
  • Has the medical training and clinical expertise suitable to treat your condition;
  • Specializes in psychiatry, if your illness or injury is caused, to any extent, by substance abuse or a mental disorder; and
  • A physician is not you or related to you.

Also, to the extent required by law, a practitioner who performs a service which coverage is provided when it is performed by a physician. These include, but may not be limited to the following:

Acupuncturist;
Chiropractor;
Optometrist;
Certified Registered Nurse Anesthetists;
Certified Nurse Midwives;
Certified Nurse Practitioner;
Registered Nurse First Assistant;
Social Workers;
Psychiatric Nurses.
Licensed Clinical Professional Counselors
Dental Hygiene Therapists
Pastoral Counselors
Marriage and Family Therapists
• **Premium(s).** The amount the **Contract Holder** or **Member** is required to pay to **HMO** to continue coverage.

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

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

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

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

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

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

• **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.

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

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

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

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

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

• **Surgery or Surgical Procedure.** The diagnosis and treatment of injury; deformity and disease by manual and instrumental means, such as cutting; abrading; suturing; destruction; ablation; removal; lasering; introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy); correction of fracture; reduction of dislocation; application of plaster casts; injection into a joint; injection of sclerosing solution; or otherwise physically changing body tissues and organs.

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

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

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

• **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.

• **Walk-in Clinic.** A Participating, free-standing health care facility **Provider** that is a treatment alternative to a Participating **Physician’s** office for unscheduled, non-Medical Emergency services and supplies to treat illnesses and injuries and the administration of certain immunizations as appropriate for such **Provider**. Neither an emergency room, not the outpatient department of a **Hospital** shall be considered a Walk-in Clinic. Services rendered at a Walk-in Clinic for ongoing care are not **Covered Benefits**.

• **E-Visit.** An on-line internet consultation between a Participating **Physician** and an established **Member** about a health care matter that is not a Medical Emergency or Urgent Care. An E-Visit shall not substitute a **Member’s** initial in-person consultation with a Participating **Provider**, and it must be conducted through an HMO vendor.

• **Residential Treatment Facility – (Mental Disorders)**

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

**Residential Treatment Facility – (Alcoholism and Drug Abuse)**

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

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

HMO TIERED NETWORK BENEFITS
SCHEDULE OF BENEFITS

Plan Name: Open Access Health Network Option
Contract Holder Name: PRESIDENT AND TRUSTEES OF BATES COLLEGE
Contract Holder Group Agreement Effective Date: January 01, 2016

Important Information About The HMO Plan

This plan provides access to covered services and supplies through a broad network of health care providers and facilities. Participating Providers have contracted with HMO, an affiliate or third party vendor to provide health care services and supplies to HMO plan Members. The plan includes Participating Providers that are identified generically throughout this form as Designated Participating Providers and Non-Designated Participating Providers. This plan pays benefits differently when services and supplies are obtained through Designated Network Providers or Non-Designated Network Providers as explained below.

Designated Participating Providers and Non-Designated Participating Providers

This plan provides preferred benefit coverage and access to certain covered services and supplies through a network of health care providers and facilities that are unique to a Member's plan. The network has been divided into two groups. In this plan, the two groups of Participating Providers are called Designated Participating Providers and Non-Designated Participating Providers. A Member's cost sharing will be lower when a Member uses Designated Participating Providers and will be higher when a Member uses Non-Designated Participating Providers. Both groups of Participating Providers are identified in the printed Directory and the on-line version of the Directory via DocFind at www.aetna.com. Members should be sure to look at the appropriate Directory that applies to their plan, since different HMO plans use different networks of Providers.

Important Note:

If a Member lives in an area with a designated network, for maximum savings, a Member must select a Designated Participating provider for care. If a Member selects a Non-Designated Participating Provider for care, a Member's out-of-pocket expenses will be higher than if the Member selected a Designated Participating Provider. Carefully read the details on cost-sharing provided later in this Schedule of Benefits.

NETWORK BENEFIT LEVELS

<table>
<thead>
<tr>
<th>deductibles</th>
<th>Designated Participating Providers Deductibles</th>
<th>Non-Designated Participating Providers Deductibles</th>
</tr>
</thead>
<tbody>
<tr>
<td>deductible amounts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Deductibles</td>
<td>$250</td>
<td>$2,000</td>
</tr>
<tr>
<td>Family Calendar Year Deductibles</td>
<td>$500</td>
<td>$4,000</td>
</tr>
</tbody>
</table>

Deductible Amounts:
1. Members have combined individual and family calendar year Deductibles that apply to Covered Benefits incurred from Designated Participating Providers and Non-Designated Participating Providers.
2. The Designated Participating Provider and Non-Designated Participating Provider Deductible amounts may not apply to certain Covered Benefits. Covered Benefits to which the Deductibles apply are shown in this Schedule of Benefits.
3. Refer to the Method of Payments provision within the HMO Tiered Network Certificate rider for
additional important information on **Deductible** amounts and how they apply under the plan.

<table>
<thead>
<tr>
<th>Maximum Out-of-Pocket Limits</th>
<th>Designated Participating Providers Maximums</th>
<th>Non-Designated Participating Providers Maximums</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maximum Out-of-Pocket Limits</strong></td>
<td>These Maximum Out-of-Pocket limits include the Deductible Amounts.</td>
<td>These Maximum Out-of-Pocket limits include the Deductible Amounts.</td>
</tr>
<tr>
<td></td>
<td>These Maximum Out-of-Pocket limits do apply to Prescription Drug Benefits.</td>
<td>These Maximum Out-of-Pocket limits do apply to Prescription Drug Benefits.</td>
</tr>
<tr>
<td></td>
<td>None. All Covered Benefits in excess of the Deductible Amount will be paid by HMO and the Member in accordance with the cost sharing provisions on this Schedule of Benefits and the Non-Referred Benefits Schedule of Benefits and any rider or amendment that applies.</td>
<td>None. All Covered Benefits in excess of the Deductible Amount will be paid by HMO and the Member in accordance with the cost sharing provisions on this Schedule of Benefits and the Non-Referred Benefits Schedule of Benefits and any rider or amendment that applies.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Individual Maximum Out-of-Pocket Limits per calendar year</th>
<th>$1,500</th>
<th>$4,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Maximum Out-of-Pocket Limits per calendar year</td>
<td>$3,000</td>
<td>$8,000</td>
</tr>
</tbody>
</table>

**Maximum Out-of-Pocket Limit Amounts.** The following applies to the plan's overall medical Maximum Out-of-Pocket Limits:

1. **Members** have combined calendar year **Individual** and **Family Maximum Out-of-Pocket Limits** that apply to **Covered Benefits** incurred from **Designated Participating Providers** and **Non-Designated Participating Providers**.
2. **Members** must demonstrate the **Designated Participating Providers** and **Non-Designated Participating Providers, Coinsurance** and **Copayments** that have been paid during the year.
3. Refer to the **Method of Payments** provision within the HMO Tiered Network **Certificate** rider(s) for additional important information on **Maximum Out-of-Pocket Limits** and how they apply under the plan.

**Maximum Benefit Amounts:**

Unless otherwise noted in this Schedule of Benefits under a specific benefit, as to any service or supply that is subject to a maximum age, visit or day limitation under this plan:

- such maximum or limitation applies separately to **Covered Benefits** incurred from **Designated Participating Providers** and **Non-Designated Participating Providers**.
## OUTPATIENT BENEFITS

### NETWORK BENEFIT LEVELS

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Designated Participating Providers</th>
<th>Non-Designated Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Copayment/Maximums</td>
<td>Copayment/Maximums</td>
</tr>
<tr>
<td>Preventive Care Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine physical exams</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performed at a physician’s office</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
</tr>
<tr>
<td></td>
<td>No deductible applies</td>
<td>No deductible applies</td>
</tr>
<tr>
<td><strong>Members</strong> ages 22 but less than 65: Maximum Visits per calendar year</td>
<td>1 visit</td>
<td>1 visit</td>
</tr>
<tr>
<td><strong>Members</strong> age 65 and over: Maximum Visits per calendar year</td>
<td>1 visit</td>
<td>1 visit</td>
</tr>
<tr>
<td>Preventive Care Immunization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performed in a facility or a physician’s office</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
</tr>
<tr>
<td></td>
<td>No deductible applies</td>
<td>No deductible applies</td>
</tr>
<tr>
<td><strong>Members</strong> through age 22</td>
<td>Subject to any age and visit limits provided for in the current comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.</td>
<td>Subject to any age and visit limits provided for in the current comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.</td>
</tr>
<tr>
<td><strong>Members</strong> ages 22 but less than 65</td>
<td>For details, contact your PCP, log onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or call the number on the back of the ID card</td>
<td>For details, contact your PCP, log onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or call the number on the back of the ID card</td>
</tr>
<tr>
<td><strong>Members</strong> age 65 and over:</td>
<td>Subject to any age and visit limits provided for in the current comprehensive guidelines supported by the Health Resources and Services Administration.</td>
<td>Subject to any age and visit limits provided for in the current comprehensive guidelines supported by the Health Resources and Services Administration.</td>
</tr>
<tr>
<td>Well Woman Preventive Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performed at a physician’s, obstetrician (OB), gynecologist (GYN) or OB GYN office</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
</tr>
<tr>
<td></td>
<td>No deductible applies</td>
<td>No deductible applies</td>
</tr>
<tr>
<td><strong>Maximum</strong></td>
<td>Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.</td>
<td>Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.</td>
</tr>
<tr>
<td><strong>Maximum visits per calendar year</strong></td>
<td>1 visit</td>
<td>1 visit</td>
</tr>
<tr>
<td>Preventive Screening and Counseling Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Office visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Obesity and/or healthy diet counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Misuse of alcohol and drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Use of tobacco products</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sexually transmitted infection counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Genetic risk counseling for breast and ovarian cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$0 per visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No deductible applies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$0 per visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No deductible applies</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Obesity and/or healthy diet counseling maximums:**

<table>
<thead>
<tr>
<th>Maximum visits per day</th>
<th>1 visit*</th>
<th>1 visit*</th>
</tr>
</thead>
<tbody>
<tr>
<td>(this maximum applies only to covered persons age 22 and older)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum visits per calendar year</td>
<td>26 visits (however, of these only 1 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*</td>
<td>26 visits (however, of these only 1-2 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*</td>
</tr>
</tbody>
</table>

* Note: in figuring the maximum visits, each session of up to 60 minutes is equal to one visit

**Misuse of Alcohol and/or drugs maximums:**

<table>
<thead>
<tr>
<th>Maximum visits per day</th>
<th>1 visit*</th>
<th>1 visit*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum visits per calendar year</td>
<td>5 visits*</td>
<td>5 visits*</td>
</tr>
</tbody>
</table>

* Note: in figuring the maximum visits, each session of up to 60 minutes is equal to one visit

**Use of tobacco products maximums:**

<table>
<thead>
<tr>
<th>Maximum visits per day</th>
<th>1 visit*</th>
<th>1 visit*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum visits per calendar year</td>
<td>8 visits*</td>
<td>8 visits*</td>
</tr>
</tbody>
</table>

* Note: in figuring the maximum visits, each session of up to 60 minutes is equal to one visit

**Genetic risk counseling for breast and ovarian cancer maximums:**

| Genetic risk counseling for breast and ovarian cancer | Not subject to any age or frequency limitations | Not subject to any age or frequency limitations |

* Note: in figuring the maximum visits, each session of up to 60 minutes is equal to one visit
### Routine Cancer Screenings
Applies whether performed at a physician’s office, specialist office or facility.

<table>
<thead>
<tr>
<th>Routine cancer screenings</th>
<th>$0 per visit</th>
<th>$0 per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No copayment or deductible applies</td>
<td>No deductible applies</td>
</tr>
</tbody>
</table>

**Maximums**
Subject to any age, family, history and frequency guidelines as set forth in the most current:
- Evidence based items that have a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and
- The comprehensive guidelines supported by the Health Resources and Services Administration

For details, contact your PCP, log onto the Aetna website www.aetna.com, or call the number on the back of the ID card.

### Prenatal Care Services
Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN) and/or OB/GYN)

<table>
<thead>
<tr>
<th>Preventive Care Services only</th>
<th>$0 per visit</th>
<th>$0 per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No copayment or deductible applies</td>
<td>No deductible applies</td>
</tr>
</tbody>
</table>

Note: You should review the Maternity and Related Newborn Care sections of this Schedule of Benefits, for a more detailed description of maternity coverage under this plan.

### Comprehensive Lactation Support and Counseling Services

<table>
<thead>
<tr>
<th>Lactation Counseling Services – facility or office visits</th>
<th>$0 per visit</th>
<th>$0 per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No copayment or deductible applies</td>
<td>No deductible applies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lactation Counseling Services Maximum Visits per calendar year</th>
<th>6 visits*</th>
<th>6 visits*</th>
</tr>
</thead>
</table>

Note: Any visit that exceeds the lactation counseling Services Maximum is covered under the physician’s services office visits.

### Breast Feeding Durable Medical Equipment

<table>
<thead>
<tr>
<th>Breast pump supplies and accessories</th>
<th>$0 per visit</th>
<th>$0 per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No copayment or deductible applies</td>
<td>No deductible applies</td>
</tr>
</tbody>
</table>

Note: See the durable medical equipment section of the Certificate for any limitations that may apply to breast pumps and supplies.

### Family Planning Services – Female Contraceptives

<table>
<thead>
<tr>
<th>Female Contraceptive counseling services</th>
<th>$0 per visit</th>
<th>$0 per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No copayment or deductible applies</td>
<td>No deductible applies</td>
</tr>
</tbody>
</table>
### Counseling Services

<table>
<thead>
<tr>
<th>Contraceptive Counseling Services Maximum Visits per calendar year</th>
<th>2 visits*</th>
<th>2 visits*</th>
</tr>
</thead>
</table>

Note: Any visits that exceed the Contraceptive Counseling Services Maximum are covered under Physicians Services.

### Devices

<table>
<thead>
<tr>
<th>Female contraceptive device provided, administered or removed by a physician during an office visit</th>
<th>$0 per visit</th>
<th>$0 per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>No copayment or deductible applies</td>
<td>No deductible applies</td>
<td></td>
</tr>
</tbody>
</table>

### Female Voluntary Sterilization

<table>
<thead>
<tr>
<th>Inpatient</th>
<th>$0 per visit</th>
<th>$0 per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>No copayment or deductible applies</td>
<td>No deductible applies</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient</th>
<th>$0 per visit</th>
<th>$0 per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>No copayment or deductible applies</td>
<td>No deductible applies</td>
<td></td>
</tr>
</tbody>
</table>

### Primary Care Physician Services

<table>
<thead>
<tr>
<th>Office Hours Visits (Non-surgical)</th>
<th>$20 per visit</th>
<th>$40 per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>After-Office Hours and Home Visits</td>
<td>$25 per visit</td>
<td>$45 per visit</td>
</tr>
</tbody>
</table>

### Walk In Clinic Visit

| Walk in Clinic visits and E-visits are not covered when services are rendered by non-participating providers. | $20 per visit | $40 per visit |

### Specialist Physician Services

| Office Visits (Non-surgical) | $25 per visit | $45 per visit |

### Prenatal Care, Delivery Services and Postnatal Care

<table>
<thead>
<tr>
<th>First Prenatal Visit(s) by the attending PCP or Obstetrician.</th>
<th>$25 per visit</th>
<th>$45 per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal care, delivery services and postnatal care provided by the attending PCP or Obstetrician.</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
</tr>
</tbody>
</table>

### Short Term Rehabilitation

| Outpatient Physical, Occupational, Speech Therapy | $25 per visit | $45 per visit |

| Treatment over a 60 consecutive day period per incident of illness or injury beginning with the first day of treatment | Treatment over a 60 consecutive day period per incident of illness or injury beginning with the first day of treatment |

### Outpatient Facility Visits

| Specialist Physician and Facility Services | $0 per visit | $0 per visit |

<p>| Treatment over a 60 consecutive day period per incident of illness or injury beginning with the first day of treatment | Treatment over a 60 consecutive day period per incident of illness or injury beginning with the first day of treatment |</p>
<table>
<thead>
<tr>
<th>Service</th>
<th>Hospital Outpatient Facility</th>
<th>Other Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic X-Ray Testing (except Complex Imaging)</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
</tr>
<tr>
<td>Complex Imaging Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Outpatient Facility</td>
<td>$50 per visit</td>
<td>$50 per visit</td>
</tr>
<tr>
<td>Other Facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Laboratory Testing</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
</tr>
<tr>
<td>Outpatient Emergency Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Emergency Room, Urgent Care Facility, or Outpatient Department</td>
<td>$100 per visit</td>
<td>$100 per visit</td>
</tr>
<tr>
<td>Urgent Care Facility - Non-Hospital</td>
<td>$25 per visit</td>
<td>$100 per visit</td>
</tr>
<tr>
<td>Ambulance Service ground ambulance or air ambulance</td>
<td>20% (of the Contracted Rate) after Deductible per trip</td>
<td>20% (of the Contracted Rate) after Deductible per trip</td>
</tr>
<tr>
<td>Outpatient Mental Disorders Visits</td>
<td>$25 per visit</td>
<td>$45 per visit</td>
</tr>
<tr>
<td>Outpatient Substance Abuse Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detoxification</td>
<td>$25 per visit</td>
<td>$45 per visit</td>
</tr>
<tr>
<td>Rehabilitation (including Partial Hospitalization and Intensive Outpatient Programs)</td>
<td>$25 per visit</td>
<td>$45 per visit</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Outpatient Facility</td>
<td>20% (of the Contracted Rate) after Deductible per visit</td>
<td>40% (of the Contracted Rate) after Deductible per visit</td>
</tr>
<tr>
<td>Specialist Physician Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Facility</td>
<td>20% (of the Contracted Rate) after Deductible per visit</td>
<td>40% (of the Contracted Rate) after Deductible per visit</td>
</tr>
<tr>
<td>Outpatient Home Health Visits</td>
<td>20% (of the Contracted Rate) after Deductible per visit</td>
<td>40% (of the Contracted Rate) after Deductible per visit</td>
</tr>
<tr>
<td>Limited to 3 intermittent visit(s) per day provided by a Participating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit</td>
<td>Designated Participating Providers</td>
<td>Non-Designated Participating Providers</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Acute Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20% (of the Contracted Rate) after Deductible per admission</td>
<td>40% (of the Contracted Rate) after Deductible per admission</td>
<td></td>
</tr>
<tr>
<td>Mental Disorders</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### ADDITIONAL BENEFITS

#### NETWORK BENEFIT LEVELS

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Designated Participating Providers Copayment/Maximums</th>
<th>Non-Designated Participating Providers Copayment/Maximums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spinal Therapy</td>
<td>$25 per visit</td>
<td>$45 per visit</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>$0 per item</td>
<td>$0 per item</td>
</tr>
<tr>
<td>Prosthetics</td>
<td>$0 per item</td>
<td>$0 per item</td>
</tr>
<tr>
<td>Autism Spectrum Disorder</td>
<td>Payable as part of, and under the same terms as, a Mental Disorder</td>
<td>Payable as part of, and under the same terms as, a Mental Disorder</td>
</tr>
<tr>
<td>Applied Behavior Analysis</td>
<td>Payable as part of, and under the</td>
<td>Payable as part of, and under the</td>
</tr>
</tbody>
</table>

**During a Hospital Confinement**
- 20% (of the Contracted Rate) after Deductible per admission
- 40% (of the Contracted Rate) after Deductible per admission

**During a Residential Treatment Facility Confinement**
- 20% (of the Contracted Rate) after Deductible per admission
- 40% (of the Contracted Rate) after Deductible per admission

**Substance Abuse**
- Detoxification and Rehabilitation
  - 20% (of the Contracted Rate) after Deductible per admission
  - 40% (of the Contracted Rate) after Deductible per admission

**Maternity**
- 20% (of the Contracted Rate) after Deductible per admission
- 40% (of the Contracted Rate) after Deductible per admission

**Skilled Nursing Facility**
- (Including Specialist Physician Services)
  - 20% (of the Contracted Rate) after Deductible per admission
  - 40% (of the Contracted Rate) after Deductible per admission

**Inpatient Hospice Care**
- (Including Specialist Physician Services)
  - 20% (of the Contracted Rate) after Deductible per admission
  - 40% (of the Contracted Rate) after Deductible per admission

**Transplant Facility Expense Services**
- Inpatient Care
  - 20% (of the Contracted Rate) after Deductible per admission
  - 20% (of the Contracted Rate) after Deductible per admission

**Maximum of 100 days per calendar year**

**ADDITIONAL BENEFITS**

**Spinal Therapy**
- $25 per visit
- $45 per visit

**Durable Medical Equipment (DME)**
- $0 per item
- $0 per item

**Prosthetics**
- $0 per item
- $0 per item

**Autism Spectrum Disorder**
- Autism Spectrum Disorders (these disorders are considered a mental health condition)
  - Payable as part of, and under the same terms as, a Mental Disorder
  - Payable as part of, and under the same terms as, a Mental Disorder

**Applied Behavior Analysis**
- Payable as part of, and under the
- Payable as part of, and under the
<table>
<thead>
<tr>
<th>Benefit</th>
<th>$0 per visit</th>
<th>$25 per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children’s Early Intervention Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum Benefit for each Child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum Benefit for each Child</td>
<td>32 Combined visits per calendar year for occupational therapists, physical therapists, speech language pathologists or clinical social workers.</td>
<td>32 Combined visits per calendar year for occupational therapists, physical therapists, speech language pathologists or clinical social workers.</td>
</tr>
<tr>
<td><strong>Diabetes Benefit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Services, equipment and training)</td>
<td>$0 per visit</td>
<td>$25 per visit</td>
</tr>
<tr>
<td><strong>Hearing Aids Benefit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Aids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>$0 after Deductible per visit</td>
<td>$0 after Deductible per visit</td>
</tr>
<tr>
<td>Covered Persons through age 18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum</td>
<td>One hearing aid per ear every 36 months</td>
<td>One hearing aid per ear every 36 months</td>
</tr>
</tbody>
</table>
### ELIGIBILITY

<table>
<thead>
<tr>
<th>Subscriber Eligibility:</th>
<th>Eligible for benefits: as defined by the Contract Holder and agreed to by HMO.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dependent Eligibility:</strong></td>
<td>A dependent child of the Subscriber as described in the Eligibility and Enrollment section of the Certificate who is:</td>
</tr>
<tr>
<td>i.</td>
<td>under 26 years of age; or</td>
</tr>
<tr>
<td>ii.</td>
<td>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</td>
</tr>
<tr>
<td>iii.</td>
<td>Dependent upon the Subscriber for support and maintenance, and is 26 years of age or older but incapable of self-support due to mental or physical incapacity, either of which commenced prior to: 26, or if a student, 26.</td>
</tr>
<tr>
<td></td>
<td>A dependent child as described in the Eligibility and Enrollment section of the Certificate who satisfies the eligibility requirements defined by the Contract Holder and agreed to by HMO.</td>
</tr>
</tbody>
</table>

### TERMINATION OF COVERAGE

<table>
<thead>
<tr>
<th>Termination of Coverage:</th>
<th>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 following the date on which the Subscriber ceased to meet the eligibility requirements.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coverage of Covered Dependents will cease end of the month following the date on which the dependent ceased to meet the eligibility requirements.</td>
</tr>
</tbody>
</table>
AETNA HEALTH INC.  
(MAINE)  

PRESCRIPTION PLAN RIDER  

Group Agreement Effective Date: January 01, 2016  

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

DEFINITIONS  

Throughout this Rider the term HMO shall mean HMO, an affiliate, or a third party vendor.  

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. Brand Name Prescription Drugs do not include those drugs classified as Generic Prescription Drugs as defined below.  

• Drug Formulary. A list of prescription drugs and insulin established by HMO, which includes both Brand Name Prescription Drugs, and Generic Prescription Drugs. This list is subject to periodic review and modification by HMO. A copy of the Drug Formulary will be available upon request by the Member or may be accessed at the HMO 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 its chemical, proprietary, or non-proprietary name, that is 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.  

• Maximum Prescription Drug Benefit. The maximum amount (if any) of prescription drug Covered Benefits for any one Member or family in a given calendar year. The maximum does not reflect or include any amount HMO may receive under a rebate arrangement between HMO and a drug manufacturer for any drugs, including any drugs on the Drug Formulary.  

• Maximum Prescription Drug Out-of-Pocket Limit. The maximum amount of Copayments that any one Member or family must pay during a calendar year. HMO will pay 100% of the Negotiated Charge for covered outpatient Brand Name and Generic Prescription Drugs for the remainder of that calendar year.  

• Negotiated Charge. As to the coverage provided under this Prescription Plan Rider, 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.
Based on its overall drug purchasing, HMO may receive rebates from the manufacturers of prescription drugs and may receive or pay additional amounts from or to third parties under price guarantees. These amounts will not change the Negotiated Charge under this Prescription Plan Rider.

- **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, an affiliate or a third party vendor, 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, an affiliate, or a third party vendor, to provide covered outpatient prescription drugs to Members.

- **Precertification Program.** For certain outpatient prescription drugs, prescribing Physicians must contact HMO to request and obtain coverage for such drugs. The list of drugs requiring precertification is subject to change by HMO. An updated copy of the list of drugs requiring precertification shall be available upon request by the Member or may be accessed at the HMO website, at www.aetna.com.

- **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 rider, 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.

- **Specialty Care Drugs.** Prescription drugs covered under this rider that include injectable, infusion and oral prescription drugs prescribed to address complex, chronic diseases with associated co-morbidities such as cancer, rheumatoid arthritis, hemophilia, multiple sclerosis and which are listed in the Specialty Care Drug list.

- **Specialty Pharmacy Network.** A network of Participating pharmacies designated to fill Specialty Care Drugs prescriptions.

- **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 Drugs 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 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 or Specialty Pharmacy Network.

B. Each prescription is limited to a maximum 90 day supply when filled at a Participating Retail or Specialty Pharmacy Network 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 or Specialty Pharmacy Network. Coverage of prescription drugs may, in HMO’s sole discretion, be subject to the Precertification Program or other HMO requirements or limitations.

C. FDA approved prescription drugs are covered when the off-label use of the drug has not been approved by the FDA for that indication, including the treatment of cancer, HIV and AIDS, 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 or other HMO requirements or limitations.

D. Emergency Prescriptions - Emergency prescriptions are covered subject to the following terms:

When a Member needs a prescription filled in an emergency or Urgent Care situation, or when the Member is traveling outside of the HMO Service Area, HMO will reimburse the Member as described below.

When a Member obtains an emergency or out-of-area Urgent Care prescription at a non-Participating Retail Pharmacy, Member must directly pay the pharmacy in full for the cost of the prescription. Member is responsible for submitting a request for reimbursement in writing to HMO with a receipt for the cost of the prescription. Reimbursement requests are subject to professional review by HMO to determine if the event meets HMO’s requirements. Upon approval of the claim, HMO will directly reimburse the Member 100% of the cost of the prescription, less the applicable Copayment specified below and any Brand Name Prescription Drug cost differentials as applicable. Coverage for items obtained from a non-Participating pharmacy is limited to items obtained in connection with covered emergency and out-of-area Urgent Care services. Members must access a Participating Retail Pharmacy for Urgent Care prescriptions inside the HMO Service Area.

When a Member obtains an emergency or Urgent Care prescription at any Participating Retail Pharmacy, including an out-of-area Participating Retail Pharmacy, Member will pay to the Participating Retail Pharmacy the Copayment(s), plus the Brand Name Prescription Drug cost differentials where applicable and as described below. Members are required to present their ID card at the time the prescription is filled. HMO will not cover claims submitted as a direct reimbursement request from a Member for a prescription purchased at a Participating Retail Pharmacy except upon professional review and approval by HMO in its sole discretion. However, emergency or Urgent Care prescriptions submitted as a direct reimbursement request from a Member for a prescription purchased at a Participating Retail Pharmacy will be reimbursed at the Participating Retail Pharmacy's Negotiated Charge, less the applicable Copayment. 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 less than a 31 day supply or more than a 90 day supply (if the Provider prescribes such amounts).

F. Additional Benefits.

The following prescription drugs, medicines, and supplies are also covered subject to the terms described in this rider:
Diabetic Supplies.

The following diabetic supplies are covered if Medically Necessary upon prescription or upon Physician’s order only at a Participating Retail or Mail Order Pharmacy. The Member must pay applicable Copayments as described in the Copayments section below.

1. Diabetic needles/syringes.
2. Test strips for glucose monitoring and/or visual reading.
3. Diabetic test agents.
4. Lancets/lancing devices.
5. Alcohol swabs.

• Contraceptives.

The following contraceptives and contraceptive devices are covered upon prescription or upon the 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.

• Self-injectable Specialty Care Drugs.

Self-injectable Specialty Care Drugs, eligible for coverage under this rider, are covered when prescribed by a Provider licensed to prescribe federal legend prescription drugs or medicines. The prescription must be filled at a Participating Retail Pharmacy or Specialty Pharmacy Network pharmacy. Coverage of Self-injectable Specialty Care Drugs may, in HMO’s sole discretion, be subject to the Precertification Program or other HMO requirements or limitations.

Food and Drug Administration (FDA) approved Specialty Care Drugs, eligible for coverage under this rider, 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 or other HMO requirements or limitations.

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 or Specialty Pharmacy Network Pharmacy for each prescription or refill at the time the prescription or refill is dispensed. The Copayment does apply to the Maximum Out-of-Pocket Limit shown in the Schedule of Benefits for the medical plan, if any.
### Prescription Drug/Medicine Quantity

<table>
<thead>
<tr>
<th></th>
<th>Generic Formulary Prescription Drugs</th>
<th>Brand Name Formulary Prescription Drugs</th>
<th>Brand Name Non-Formulary Prescription Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each 30 day supply</td>
<td>$10</td>
<td>$25</td>
<td>$40</td>
</tr>
<tr>
<td>More than a 30 day supply but less than a 91 day supply</td>
<td>$20</td>
<td>$50</td>
<td>$80</td>
</tr>
</tbody>
</table>

### H. The Maximum Prescription Drug Out-of-Pocket Limit does apply to the Maximum Out-of-Pocket Limit shown in the Schedule of Benefits for the medical plan, if any.

### EXCLUSIONS AND LIMITATIONS

The Exclusions and Limitations section of the Certificate is amended to include the following exclusions and limitations:

#### A. Exclusions.

Unless specifically covered under this rider, the following are not covered:

- 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.

- Any drug determined not to be Medically Necessary for the treatment of disease or injury unless otherwise covered under this rider.

- Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by HMO.

- Cosmetic or any drugs used for cosmetic purposes or to promote hair growth, including but not limited to health and beauty aids.

- Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps.

- Needles and syringes, except for diabetic needles and syringes.

- 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.

- 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.

- Drugs used for the purpose of weight reduction (e.g., appetite suppressants), including the treatment of obesity.

- 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.

- 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.

- Drugs prescribed for uses other than uses approved by the Food and Drug Administration (FDA) under the Federal Food, Drug and Cosmetic Law and regulations, or any drug labeled “Caution: Limited by Federal Law to Investigational Use”, or experimental drugs except as otherwise covered under this rider.

- Medical supplies, devices and equipment and non-medical supplies or substances regardless of their intended use, including but not limited to wound dressings, home test kits, blood pressure kits and Durable Medical Equipment.
• Test agents and devices, except for diabetic test agents.
• Injectable Drugs used for the purpose of treating **Infertility**, unless otherwise covered by **HMO**.
• Oral and implantable contraceptives and contraceptive devices, unless otherwise covered under this rider. Coverage is not provided if your employer is a religious organization that has elected not to provide coverage for contraceptive services or treatment.
• Prescription orders filled prior to the effective date or after the termination date of the coverage provided by this rider.
• Replacement for lost or stolen prescriptions.
• Performance, athletic performance or lifestyle enhancement drugs and supplies.
• 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.
• 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.
• Medication packaged in unit dose form. (Except those products approved for payment by **HMO**).
• Prophylactic drugs for travel.
• Drugs recently approved by the FDA, but which have not yet been reviewed by Aetna's Therapeutics Committee.
• Drugs for the convenience of **Members** or for preventive purposes.
• Drugs listed on the **Exclusions List** unless otherwise covered through a medical exception as described in this rider or unless otherwise covered under this rider.
• Injectable drugs, except for insulin and **Self-injectable Drugs**.
• Nutritional supplements.
• Smoking cessation aids or drugs.
• Growth/Height: Any treatment, device, drug or supply to increase or decrease height or alter the rate of growth, including devices to stimulate growth, and growth hormones.
• 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).
• Food and nutritional items: Any food item, including infant formulas, nutritional supplements, vitamins, including prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition. This exclusion does not apply to Metabolic Formula and Special Modified Low-Protein Food products and Amino Acid-Based Elemental Infant Formula as specifically provided for in the Covered Benefits section of the Certificate of Coverage.
• Genetics: Any treatment, device, drug, or supply to alter the body’s genes, genetic make-up, or the expression of the body’s genes except for the correction of congenital birth defects.
• Drugs, medications, injectables or supplies provided through a third party vendor contract with the **Contract Holder**.
• Drugs, services and supplies provided in connection with treatment of an occupational injury or occupational illness.
• Sex change: Any treatment, drug or supply related to changing sex or sexual characteristics, including hormones and hormone therapy.
• Sexual dysfunction/enhancement: Any drug or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ.
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. HMO is not responsible for the cost of any prescription drug for which the actual charge to the Member is less than the required Copayment or for any drug for which no charge is made to the recipient.

4. Member will be charged the Non-Formulary Prescription Drug Copayment for prescription drugs covered on an exception basis.

5. The Continuation and Conversion section of the Certificate, if any, is hereby amended to include the following provision: The conversion privilege does not apply to the HMO Prescription Plan.
ADVANCED REPRODUCTIVE TECHNOLOGY (“ART”) SERVICES RIDER

Contract Holder Group Agreement Effective Date: January 01, 2016

Aetna Health Inc., ("HMO") and Contract Holder agree to provide to Members the Advanced Reproductive Technology ("ART") Services Rider subject to the following provisions:

The Definitions section of the Certificate is hereby amended to add the following definition(s):

• **Advanced Reproductive Technology ("ART"):**
  a.  in vitro fertilization ("IVF");
  b.  gamete intra-fallopian transfer ("GIFT");
  c.  zygote intra-fallopian transfer ("ZIFT");
  d.  cryopreserved embryo transfers; or
  e.  intra-cytoplasmic sperm injection ("ICSI") or ovum microsurgery.

• **ART Services.** ART Services, products, or procedures that are Covered Benefits under the Certificate and/or this Rider.

• **Infertility Case Management.** A program administered by HMO that consists of:
  a.  evaluation of Infertile Members' medical records to determine whether ART Services are Medically Necessary and are reasonably likely to result in success;
  b.  determination of whether ART Services are Covered Benefits for the Member;
  c.  pre-authorization for ART Services by a Participating ART Specialist when ART Services are Medically Necessary, reasonably likely to result in success, and are Covered Benefits; and
  d.  case management for the provision of ART Services for eligible Members.

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

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

• **Advanced Reproductive Technology Services Benefits.**

  **Member Eligibility.** To be eligible for benefits under this Rider, a Member must:
  a.  be covered under the Certificate as a Subscriber or a Covered Dependent who is the Subscriber's legal spouse;
  b.  exhaust HMO's Comprehensive Infertility Services benefits (refer to the Comprehensive Infertility Services Rider for covered Comprehensive Infertility Services benefits); and
  c.  have a condition that is a demonstrated cause of Infertility as recognized by a Participating ART Specialist and documented in the Member's medical records.
To obtain covered ART Services benefits as described in this Rider, a Member must be:

a. referred by the Member's PCP or Participating gynecologist to the Infertility Case Management Unit, or the Member may directly contact HMO's Infertility Case Management Unit;

b. recommended for ART treatment by a Participating ART Specialist after an initial intake evaluation and consultation with the Participating ART Specialist;

c. determined by HMO to be eligible for participation in HMO's Infertility Program and pre-authorized by HMO for the ART Services benefit; and

d. issued pre-authorization for ART Services from HMO's Infertility Case Management Unit to a Participating ART Specialist with appropriate Referrals.

The following benefits are covered when all of the above conditions are met, subject to the Exclusions and Limitations section of the Certificate and this Rider:

a. up to 3 cycles of any combination of the following ART Services per lifetime (where lifetime is defined to include services provided or administered by HMO or any affiliated company of HMO, or any other health benefits plan, or where no plan coverage was provided) which only include: IVF; GIFT; ZIFT; or cryopreserved embryo transfers;

b. ICSI or ovum microsurgery;

c. payment for charges associated with the care of the Member who is participating in a donor IVF program, including fertilization and culture; and

d. charges associated with obtaining the Member's spouse's sperm for ART, when the spouse is also a Member.

The Exclusions and Limitations section of the Certificate is hereby amended to add the following exclusion(s):

• **Advanced Reproductive Technology Services**, including but not limited to:

  1. ART Services for female Members attempting to become pregnant who have not had at least 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination (for Members less than 35 years of age), or 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination (for Members 35 years of age or older) prior to enrolling in HMO's Infertility Program;

  2. ART Services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;

  3. Reversal of sterilization surgery;

  4. ART Services for female Members with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;

  5. The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the Member or the gestational carrier;

  6. Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, Hospital, ultrasounds, laboratory tests, etc.);
7. Home ovulation prediction kits;
8. Drugs related to the treatment of non-covered benefits or related to the treatment of Infertility that are not Medically Necessary;
9. Injectable Infertility medications, including but not limited to, menotropins, hCG, GnRH agonists, and IVIG;
10. Any service provided without a Referral or pre-authorization from HMO's Infertility Case Management Unit;
11. ART Services that are not reasonably likely to result in success.

The Exclusions and Limitations section of the Certificate is hereby amended to add the following limitation(s):

- ART Services are available only from the Participating ART Specialists for whom the Member has been issued a pre-authorization by HMO's Infertility Case Management Unit. Treatment received from a non-participating Provider or without a pre-authorization will not be covered and the Member will be responsible for payment of all services. Coverage for ART Services are only provided for referred care.

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

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 Advanced Reproductive Technology (“ART”) Services Rider.

The Schedule of Benefits is hereby amended to add the following:

**ADVANCED REPRODUCTIVE TECHNOLOGY (“ART”) SERVICES BENEFITS**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Copayment/Maximums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once the Member has exhausted either the ART Services and Comprehensive Infertility Services Combined Maximum Benefit or the cycle maximum listed in this Rider and the Comprehensive Infertility Services Rider, no additional ART Services or Comprehensive Infertility Services are covered.</td>
<td></td>
</tr>
</tbody>
</table>

If the overall plan Maximum Benefit shown in the Schedule of Benefits is exhausted, no additional ART Services are covered.
AETNA HEALTH INC.
(MAINE)

DOMESTIC PARTNER RIDER

Certificate of Coverage Group Agreement Effective Date: January 01, 2016

Subsection A.2.a of the Eligibility and Enrollment section of the Certificate is hereby deleted and replaced with the following:

Section B. 3. a. of The Eligibility; Effective Date of Coverage section of the Certificate of Coverage is hereby deleted and replaced with the following:

a. The Subscriber’s 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. is a mentally competent adult;
ii. has a close, committed and monogamous personal relationship;
iii. has been sharing the same household on a continuous basis for at least 6 months;
iv. is not married to, or separated from, another individual;
v. demonstrates evidence of domestic partnership by submission of an affidavit of partnership, if requested, which shows documentation of:

a) common ownership of real property or a common leasehold interest in such property;
b) common ownership of joint personal property;
c) joint bank accounts or credit accounts; or
d) assignment of a durable power of attorney or health care power of attorney.

Subscriber may not enroll another individual as a domestic partner under an individual or group contract until 12 months after the termination of coverage for a prior domestic partner.

HMO may request documentation of any of the foregoing prior to commencing coverage for a domestic partner; or
AETNA HEALTH INC.  
(Maine)  

AETNA OPEN ACCESS RIDER  

Contract Holder Group Agreement Effective Date: January 01, 2016  

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

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

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

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

B. The Primary Care Physician (PCP).  

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

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

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

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

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

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

• Self-Referred Services.  

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

Under this provision, a Member may directly access Participating Specialists, ancillary Providers and facilities for Covered Benefits without a PCP Referral, subject to the terms and conditions of the Certificate and any cost-sharing requirements set forth in the Schedule of Benefits. Participating Providers will be responsible for obtaining pre-authorization of services from HMO.  

Except as described in this Rider, the Covered Benefits section and the Exclusions and Limitations section
of the Certificate remain unchanged and the ability of a Member to directly access Participating Providers does not alter any other provisions of the Certificate. Except for Emergency Services and out-of-area Urgent Care services, a Member must access Covered Benefits from Participating Providers and facilities or benefits will not be covered under this Certificate and a Member will be responsible for all expenses incurred unless HMO has pre-authorized the services to a non-participating Provider.

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

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

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

- Unauthorized services obtained by the Member that require pre-authorization by HMO including but not limited to Hospital admissions and outpatient surgery. Participating Providers are responsible for obtaining pre-authorization of Covered Benefits from HMO.

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

- Upon pre-authorization, other treatment plans may be subject to case management and a Member may be directed to specific Participating Providers for Covered Benefits including, but not limited to transplants and other treatment plans.

- Supplemental plans provided under a separate contract or policy in addition to an HMO health benefit plan, including but not limited to dental plans and behavioral health plans, are not subject to the provisions of this Rider and a Member is required to abide by the terms and conditions of the separate contract or policy.

The Continuation and Conversion section of the Certificate is amended to include the following provision:

- The conversion privilege does not apply to the Aetna Open Access Rider.
Wellness Incentive Rider

Aetna Health Inc. (“HMO”) and Contract Holder agree to provide to Members the Wellness Benefit Rider subject to the following provisions.

1. The Certificate is amended to include the following:

   **Wellness Benefit**
   Upon completion of a health assessment, Members are eligible to participate in wellness activities that align with a Member’s results. A list of wellness activities, such as smoking cessation and weight management, is available from HMO or the Contract Holder. To contact HMO, call the Member Services phone number appearing on your identification card.

   For completing wellness activities, Members will receive a benefit award amount. The plan may also have a maximum benefit per calendar year. The type and value of a benefit award amount and the maximum benefit are chosen by the Contract Holder. The benefit award amount for completed wellness activities is shown in the Schedule of Benefits.

   A Member may use the benefit award amount to reduce any applicable Deductible or Coinsurance limit required under this plan.

   Only the Subscriber and a covered dependent spouse and dependent are eligible for wellness incentives.

2. The Schedule of Benefits of the Certificate is amended to include the following:

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Award Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Award Amount:</td>
<td>$50</td>
</tr>
<tr>
<td>Calendar Year Individual Maximum Benefit:</td>
<td>$50</td>
</tr>
<tr>
<td>Calendar Year Family Maximum Benefit:</td>
<td>$100</td>
</tr>
</tbody>
</table>

   **ALL BENEFITS ARE SUBJECT TO THE PROVISIONS IN THE CERTIFICATE, INCLUDING COORDINATION OF BENEFITS (COB).**

   **MISCELLANEOUS PROVISIONS**

   In the event of any conflict between this Rider and the Group Agreement, this Rider shall prevail. This Rider shall not vary, alter, waive, or extend any of the terms, conditions, provisions, or limitations of the Group Agreement, other than as stated above.
NON-REFERRED BENEFITS UNDER THE OPEN ACCESS HEALTH NETWORK OPTION PROGRAM

This Rider is to be used in conjunction with the HMO Certificate of Coverage, which is made up of the HMO Certificate of Coverage, Schedule of Benefits, any riders, and any amendments, endorsements, inserts, or attachments. Together, this Rider and the HMO Group Agreement is referred to as the Open Access Health Network Option.

This program provides coverage for Referred and Self-Referred Benefits received from Participating Providers and Non-Referred Benefits received from Non-Participating Providers. This Rider details Non-Referred Benefits accessed through Non-Participating Providers and the HMO Certificate of Coverage details Referred Benefits and Self-Referred Benefits accessed through Participating Providers. Members must be covered by the HMO Certificate of Coverage to be eligible for benefits under this Rider.

Important

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

Contract Holder: PRESIDENT AND TRUSTEES OF BATES COLLEGE
Contract Holder Number: 0869807
Contract Holder Group Policy Effective Date: January 01, 2016
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</tbody>
</table>
NON-REFERRED PROCEDURE

A. You Must Have Coverage with HMO.

A Member must be covered by HMO for the health benefits listed in the HMO Certificate of Coverage in order to be eligible to be covered by this Rider. If a Member is not covered under the HMO Certificate of Coverage or fails to remain covered under the HMO Certificate of Coverage, the Member cannot be covered under this Rider.

B. Legal Relationship.

This Rider establishes a legal relationship between the Member and HMO. The Member is entitled to receive from HMO only the benefits specified in this Rider.

C. Benefits Available Through the Open Access Health Network Option Program.

This Rider provides coverage in the event the Member seeks Non-Referred Benefits.

HMO must be contacted for Precertification prior to receiving certain services or supplies that are identified in this Rider as requiring Precertification in order to avoid a reduction in benefits.

D. The HMO Certificate of Coverage.

The Member’s eligibility to receive HMO Benefits under the HMO Certificate of Coverage makes the Member eligible to receive coverage under this Rider for Non-Referred Covered Benefits. A copy of the HMO Certificate of Coverage, to which this Rider is attached, is made part of this Certificate. In case of any discrepancy in meaning, this Rider shall control Covered Benefits for Non-Referred Benefits under the Open Access Health Network Option Program.

E. HMO and Open Access Health Network Option.

Benefits received under the HMO Certificate of Coverage, and Non-Referred Benefits that a Member receives under this Rider, do not duplicate each other. A service or supply which is a covered benefit under the HMO Certificate of Coverage is not a Covered Benefit under this Rider. Any HMO Benefits that a Member receives under the HMO Certificate of Coverage, and any benefits that a Member receives under this Rider, will be combined when calculating the maximum benefits which a Member is entitled to receive under either Certificate. Benefit limits offset and do not duplicate each other. The benefits provided under this Rider are offered only in conjunction with and as a supplement to HMO Benefits. Any HMO Benefits covered by rider(s), amendment(s) and/or endorsement(s) to the HMO Certificate of Coverage are not part of this Certificate and are excluded from coverage hereunder, unless such services are specifically included in the Covered Benefits section of this Rider. This paragraph is not applicable to the Maximum Benefit for all Services and Supplies listed on the non-referred Schedule of Benefits.

Copayments paid by Members for HMO Benefits received under the HMO Certificate of Coverage, including any rider(s), amendment(s), and/or endorsement(s), shall not apply in satisfying the Deductible or Coinsurance limits under this Rider.

F. Ongoing Reviews.

HMO conducts ongoing reviews of those services and supplies which are recommended or provided by Health Professionals to determine whether such services and supplies are Covered Benefits under this Rider. If HMO determines that the recommended services and supplies are not Covered Benefits, the Member will be notified. If a Member wishes to appeal such determination, the Member may then contact HMO to seek a review of the determination. Please refer to the Grievance Procedure section of this Rider.
G. Precertification (or Precertified).

Prior to being hospitalized or receiving certain other Medical Services or supplies there are certain Precertification procedures that must be followed.

A Member, or a member of the Member’s family, a Hospital staff member, or the attending Physician, must notify HMO to Precertify the admission or treatment, as the case may be, prior to receiving any of the services or supplies that require Precertification pursuant to this Rider.

To obtain Precertification, call HMO at the telephone number listed on the Member’s identification card. This call must be made:

1. prior to any planned admission into a Hospital and prior to receiving such other services that require Precertification under this Rider;

2. as soon as possible after the attending Physician confirms that a Member is pregnant and again within 24 hours of the birth or as soon thereafter as possible.

The Member may request a review of the Precertification decision pursuant to the Grievance Procedure section of this Rider.

Services and Supplies Which Require Precertification

Ambulatory Surgery
Cardiac Rehabilitation - outpatient
Chemotherapy
Durable Medical Equipment (Precertification required for equipment leased or purchased over $1500)
Genetic Counseling or Testing
Home Health Services
Hospice Care - inpatient and outpatient
Hospital Admissions, except for admissions related to Emergency Services
Infertility Treatment
Laser Assisted Uvulopalatoplasty (LAUPP)
Maternity
Mental Health Services, except in the case of Emergency Services - inpatient
MRA
MRI – knee, spine
Occupational Therapy - outpatient
Oral Surgery
Osteoporosis
PET Scan
SPECT Scan
Temporomandibular Joint Disorder Treatment
Transplants
Physical Therapy - outpatient
Private Duty Nursing
Prosthetics
Pulmonary Rehabilitation
Radiation Treatment
Respiratory Therapy- outpatient
Skilled Nursing - inpatient and outpatient
Speech Therapy- outpatient
Substance Abuse Services - inpatient and outpatient
Surgery
H. **Precertification Penalty.**

HMO will reduce the benefits payable under this Rider by the percentage or dollar amount set forth on the non-referred Schedule of Benefits if the procedures for Precertification set forth in this Rider are not followed. The Member will be responsible to pay the unpaid balance of the benefits.

**FAILURE TO PRECERTIFY WILL RESULT IN A REDUCTION OF BENEFITS UNDER THIS RIDER. PLEASE REFER TO THE NON-REFERRED SCHEDULE OF BENEFITS FOR THE PRECERTIFICATION PENALTY.**

The additional percentage or dollar amount of the usual, customary, and reasonable charge (UCR) which a Member may pay as a penalty for failure to obtain Precertification under this section is not a Covered Expense, and will not be applied to the Deductible amount or the Maximum Out-of-Pocket Limit, if any.

**ELIGIBILITY**

In order to be eligible to receive benefits and to be covered under this Rider, a Member first must be eligible to receive benefits as a Subscriber or as a dependent of a Subscriber under the HMO Certificate of Coverage, and be covered under it.

The **Effective Date of Coverage** under this Rider shall be the same date as the **Effective Date of Coverage** under the HMO Certificate of Coverage.

**METHOD OF PAYMENT: DEDUCTIBLES, COINSURANCE AND COPAYMENT**

A Member first must satisfy the Deductible amount, if any, listed on the non-referred Schedule of Benefits before Non-Referred Benefits are reimbursed. Thereafter, the Member must pay a Coinsurance portion of the Covered Expenses for Non-Referred Benefits that the Member received.

A. **The Deductible.**

A Member will be eligible for reimbursement of Covered Benefits after the Member has satisfied the Deductible amount, if any, specified on the non-referred Schedule of Benefits.

The Deductible applies to each Member, subject to any family Deductible listed on the non-referred Schedule of Benefits. For purposes of the Deductible, “family” means the Subscriber and Covered Dependents. The Deductible must be satisfied once each calendar year except for;

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

B. **The Coinsurance.**

After the Deductible amount has been satisfied, HMO will pay the percentage of the UCR rate for Covered Expenses set forth in the Covered Benefits section of this Rider.

C. **Charges in Excess of UCR.**

The Member will be responsible for charges in excess of HMO’s contractual liability under this Rider. Charges by a Provider in excess of UCR will not be covered by HMO and will not be counted toward the Member’s Deductible amount or Maximum Out-of-Pocket Limit, if any, shown on the non-referred Schedule of Benefits.
D. Maximum Out-of-Pocket Limit.

If a Member’s Coinsurance payments reach the Maximum Out-of-Pocket Limit set forth on the non-referred Schedule of Benefits, HMO will pay 100% of the UCR charges for Covered Benefits during that calendar year, up to the Maximum Benefit listed on the non-referred Schedule of Benefits. Covered Benefits must be rendered to the Member during that calendar year. Charges in excess of UCR charges and the additional percentage or dollar amount of UCR charges which a Member may pay as a penalty for failure to obtain Precertification will not be applied to the Maximum Out-of-Pocket Limit and not eligible for 100% reimbursement.

E. Benefit Limitations.

HMO will provide coverage to Members up to the Maximum Benefit for all Services and Supplies set forth on the non-referred Schedule of Benefits. Covered Benefits applied toward satisfaction of the Deductible will be counted toward any applicable visit or day maximums for Covered Benefits under this Rider.

F. Calculations; Determination of UCR; Determination of Benefits.

A Member’s financial responsibility for the costs of care will be calculated on the basis of when the service or supply is provided, not when payment is made. Charges will be pro-rated to account for treatment or portions of stays that occur in more than one calendar year. HMO reserves the right and sole discretion to determine the UCR rate. It is solely within the discretion of HMO to determine when expenses are covered under this Rider. Provisions are subject to the Grievance Procedure and External Review sections in the HMO Certificate of Coverage.

COVERED BENEFITS

A Member shall be entitled to the Covered Benefits as specified below, in accordance with the terms and conditions of this Rider. Unless specifically stated otherwise, in order for expenses to be covered, they must be Medically Necessary and the Covered Benefit must be performed by a Provider that is licensed to perform such services. For the purpose of coverage, HMO may determine whether any benefit provided under the Rider is Medically Necessary. Preventive care, as described below, will be considered Medically Necessary.

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

To be Medically Necessary, the service or supply must:

• be consistent with generally accepted standards of medical practice;
• be clinically appropriate in terms of type, frequency, extent, site and duration;
• be demonstrated through scientific evidence to be effective in improving health outcomes;
• be representative of “best practices” in the medical profession; and
• be not primarily for the convenience of the Member or Physician.

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

• information provided on the Member's health status;
• reports in peer reviewed medical literature;
• reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;

• professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;

• the opinion of Health Professionals in the generally recognized health specialty involved;

• the opinion of the attending Physicians, which have credence but do not overrule contrary opinions; and

• any other relevant information brought to HMO’s attention.

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

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

THE MEMBER IS RESPONSIBLE FOR PAYMENT OF THE APPLICABLE DEDUCTIBLE AND COINSURANCE OR COPAYMENTS LISTED ON THE NON-REFERRED SCHEDULE OF BENEFITS. BENEFITS ARE SUBJECT TO THE LIMITS, IF ANY, SHOWN ON THE NON-REFERRED SCHEDULE OF BENEFITS.

IMPORTANT: REFER TO THE NON-REFERRED PROCEDURE SECTION OF THIS RIDER FOR THE LIST OF SERVICES AND SUPPLIES WHICH REQUIRE PRECERTIFICATION.

• Primary Care Physician Benefits (PCP).

  1. Office visits during office hours.

  2. Home visits.

  3. After-hours PCP services.

  4. Hospital visits.

  5. Diabetic Equipment, Supplies and Education. The following equipment, supplies and education services for the treatment of diabetic conditions are covered when ordered by the Member’s PCP and obtained through a Provider:

     a. Insulin;
     b. Oral hypoglycemic agents;
     c. Glucose monitors;
     d. Glucose test strips;
     e. Syringes;
     f. Lancets.

     Coverage for diabetes outpatient self-management training and educational services that are provided through ambulatory diabetes education facilities authorized by the State’s Diabetes Control Project within the Bureau of Health.

  6. Metabolic Formula and Special Modified Low-Protein Food Products. Coverage shall include metabolic formula and special low-protein food products that have been prescribed by a licensed Physician for a Member with an inborn error of metabolism. An inborn error of metabolism means a genetically determined biochemical disorder in which a specific enzyme defect produces
a metabolic block that may have pathogenic consequences at birth or later in life. A special modified low-protein food product means food formulated to reduce the protein content to less than one gram of protein per serving and does not include foods naturally low in protein. Benefit shall provide for a maximum of $3000 per calendar year.

**Important:** Refer to the Non-Referred Procedure section of this Rider for the list of services and supplies which require Precertification.

- **Diagnostic Services Benefits.**
  1. EKGs, and other diagnostic and treatment services.
  2. Diagnostic laboratory and radiology services.
  3. Primary preventive care subject to the maximum limits, if any, listed on the Schedule of Benefits;
     - Screening mammogram benefits for female **Members** are provided as follows:
       - age 40 and older, one routine mammogram every year; or
       - when **Medically Necessary**.
     - Routine GYN exam.
     - Immunizations for adults.
     - Routine cytologic screening for female **Members** age 18 or over.
     - Routine Pap smear.
     - Routine physicals for children and adults.
     - Routine prostate specific antigen test for males ages 50 or older.
     - Well-child care, including childhood immunizations as recommended by the Advisory Committee on Immunizations Practices of the United States Public Health Service and the Department of Health.

**Important:** Refer to the Non-Referred Procedure section of this Rider for the list of services and supplies which require Precertification.

- **Specialist Physician Benefits.**
  **Covered Benefits** include outpatient and inpatient services.
  Coverage is also provided for second medical opinions regarding a proposed surgery or course of treatment recommended by a **Physician**.

**Important:** Refer to the Non-Referred Procedure section of this Certificate for the list of services and supplies which require Precertification.

- **Maternity Care and Related Newborn Care Benefits.**
  Outpatient and inpatient pre-natal and postpartum care and obstetrical services are **Covered Benefits**.
  Coverage for maternity care and related newborn care benefits is provided to the extent covered by this **Rider** for **Specialist Physician** benefits and inpatient **Hospital** benefits, and is subject to the limits, if any, shown on the non-referred Schedule of Benefits.
As an exception to the **Medically Necessary** requirements of this **Rider**, the following coverage is provided for a mother and newly born child:

1. a minimum of 48 hours of inpatient care in a **Hospital** following a vaginal delivery;
2. a minimum of 96 hours of inpatient care in a **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 **Providers** in consultation with the mother.

If a **Member** requests a shorter **Hospital** stay, the **Member** will be covered for 1 home health care visit scheduled to occur within 24 hours of discharge. An additional visit will be covered when prescribed by the **Provider**. This benefit is in addition to the home health maximum number of visits, if any, shown on the non-referred Schedule of Benefits. A **Copayment** or **Coinsurance** will not apply for these home health care visits.

**Important:** Refer to the Non-Referred Procedure section of this Rider for the list of services and supplies which require Precertification.

- **Inpatient Hospital Benefits.**

  A **Member** is covered for inpatient **Hospital** services and supplies. Private accommodations will be provided when **Medically Necessary** as determined by HMO, upon certification by the **Physician** or HMO. Without such certification, only a semi-private room and board accommodations will be considered a **Covered Benefit**.

  **Important:** Refer to the Non-Referred Procedure section of this Rider for the list of services and supplies which require Precertification.

- **Skilled Nursing Facility Benefits.**

  A **Member** is covered for **Skilled Care** in a **Skilled Nursing Facility**. Coverage for **Skilled Nursing Facility** benefits is subject to the limits, if any, shown on the non-referred Schedule of Benefits.

  **Important:** Refer to the Non-Referred Procedure section of this Rider for the list of services and supplies which require Precertification.

- **Transplants Benefits.**

  Transplants which are non-experimental or non-investigational are a **Covered Benefit**. 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. The attending **Physician** must certify that the transplant is **Medically Necessary**, and the **Member** must be the recipient. Coverage is subject to the limits, if any, listed on the non-referred Schedule of Benefits.

  **Important:** Refer to the Non-Referred Procedure section of this Rider for the list of services and supplies which require Precertification.

- **Outpatient Surgery Benefits.**

  Coverage is provided for outpatient surgical services and supplies in connection with a covered surgical procedure when furnished by an outpatient surgery center.
Important: Refer to the Non-Referred Procedure section of this Rider for the list of services and supplies which require Precertification.

- **Substance Abuse Benefits.**

A **Member** is covered for the following services and supplies provided by **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) for the abuse of or addiction to alcohol or drugs.

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

   **Important: Refer to the Non-Referred Procedure section of this Rider for the list of services and supplies which require Precertification.**

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.

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

   **Important: Refer to the Non-Referred Procedure section of this Rider for the list of services and supplies which require Precertification.**

- **Mental Health Benefits.**

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

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

   **Important: Refer to the Non-Referred Procedure section of this Rider for the list of services and supplies which require Precertification.**

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

   **Important: Refer to the Non-Referred Procedure section of this Rider for the list of services and supplies which require Precertification.**

3. **Biologically based mental or nervous conditions.** Member shall be covered for the medical treatment and diagnosis of a biologically based mental or nervous condition as defined by the most recent edition of the American Psychiatric Association’s “Diagnostic and Statistical Manual or
Mental Disorders”. Member shall be covered under the same terms and conditions and which are no less extensive than coverage provided for any other type of health care for physical illness upon diagnosis of one or more of the following conditions by a Provider.

- **Schizophrenia**
- **Bipolar disorders**
- **Pervasive development disorder, or autism**
- **Paranoia**
- **Panic disorder**
- **Obsessive-compulsive disorder; or**
- **Major depressive disorder**

**Important:** Refer to the Non Referred Procedure section of this Rider for the list of services and supplies which require Precertification.

**Emergency Care/Urgent Care Benefits.**

1. A **Member** is covered for Emergency Services and Urgent Care benefits without Precertification, provided the services are Covered Benefits, and HMO's review determines that a Medical Emergency existed at the time medical attention was sought by the Member.

   Medical transportation is covered during a Medical Emergency.

2. A **Member** is covered for any follow-up care. Follow-up care is any care directly related to the need for Emergency Services or Urgent Care which is provided to a **Member** after the Medical Emergency care or Urgent Care situation has terminated.

**Outpatient Rehabilitation Benefits.**

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

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

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

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

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

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

**Important:** Refer to the Non-Referred Procedure section of this Rider for the list of services and supplies which require Precertification.
• **Home Health Benefits.**

The following services and supplies are covered when rendered by a **Home Health Care Agency**, and coordinated and **Precertified** by HMO. HMO shall not be required to provide home health benefits when HMO determines the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide appropriate care.

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

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

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

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

Coverage is subject to the limits, if any, shown on the non-referred Schedule of Benefits.

**Important:** Refer to the Non-Referred Procedure section of this Rider for the list of services and supplies which require Precertification.

• **Hospice Benefits.**

**Hospice Care** services and supplies 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 in the Home Health Benefits section of this **Rider**.

Coverage is not provided for funeral arrangements, financial or legal counseling, Homemaker or caretaker services, and any service not solely related to the care of the **Member**, 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 subject to the limits, if any, shown on the non-referred Schedule of Benefits.

**Important:** Refer to the Non-Referred Procedure section of this Rider for the list of services and supplies which require Precertification.

• **Prosthetic Appliances Benefits.**

The **Member's** initial provision and replacement of a prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease or injury or congenital defects is covered, when such device is prescribed by a **Provider**. Coverage includes repair due to normal wear and tear, and replacement when due to congenital growth. Instruction and appropriate services required for the **Member** to properly use the item (such as attachment or insertion) are covered. Covered prosthetic appliances include those items covered by Medicare unless excluded in the Exclusions and Limitations section of this **Rider**. 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.

**Important:** Refer to the Non-Referred Procedure section of this Rider for the list of services and supplies which require Precertification.
• **Infertility Services Benefits.**

Infertility services and supplies to diagnose the underlying medical cause of Infertility are covered. All other Infertility services and supplies are not covered.

**Important:** Refer to the Non-Referred Procedure section of this Rider for the list of services and supplies which require Precertification.

• **Pre-treatment Tests and Opinions Benefits.**

Coverage is provided for tests which are ordered by a Physician and given to a Member prior to the Member’s admission to a Hospital as a registered bed inpatient. The tests must be necessary and consistent with the diagnosis and treatment of the condition for which Hospital care is required. Also, the Hospital admission must take place within 14 days after the tests are given, unless such tests or other medical condition indicate otherwise.

**Important:** Refer to the Non-Referred Procedure section of this Rider for the list of services and supplies which require Precertification.

• **Private Duty Nursing Benefits.**

Coverage is provided for the charges for private duty professional nursing services from a L.P.N. or R.N. for a Member’s non-hospitalized acute-illness or injury. Private duty nursing care furnished for Custodial Care is not covered. Benefits are subject to the limits, if any, shown for these benefits on the non-referred Schedule of Benefits.

**Important:** Refer to the Non-Referred Procedure section of this Rider for the list of services and supplies which require Precertification.

• **Breast Cancer Treatment Benefits.**

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

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

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

**Important:** Refer to the Non-Referred Procedure section of this Rider for the list of services and supplies which require Precertification.

• **Contraceptives.**

Consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of contraceptive methods.

Coverage is not provided if your employer is a religious organization who has elected not to provide coverage for contraceptive services or treatment.
Important: Refer to the Non-Referred Procedure section of this Rider for the list of services and supplies which require Precertification.

- **Chiropractic Benefits.**

  Services to treat neuro-musculoskeletal conditions by a Provider, including licensed chiropractors, when Medically Necessary are covered.

  Coverage is subject to the limits, if any, shown on the non-referred Schedule of Benefits.

- **Durable Medical Equipment Benefits.**

  Coverage is provided for Durable Medical Equipment. The wide variety of Durable Medical Equipment and continuing development of patient care equipment makes it impractical to provide a complete listing of covered items, therefore, the HMO Medical Director has the authority to approve requests on a case-by-case basis. Coverage for Durable Medical Equipment includes those items covered by Medicare unless excluded in the Exclusions and Limitations section of this Rider. HMO reserves the right to cover only 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 Precertification by HMO. Replacement, repairs and maintenance are covered only if it is demonstrated to 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.

  Coverage is subject to the limits, if any, shown on the non-referred Schedule of Benefits.

  Important: Refer to the Non-Referred Procedure section of this Rider for the list of services and supplies which require Precertification.

**EXCLUSIONS AND LIMITATIONS**

**A. Exclusions.**

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

- Ambulance services, for routine transportation to receive outpatient or inpatient services.
- Any service that exceeds the Maximum Benefit listed on the non-referred Schedule of Benefits.
- 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, and immunoglobulins, 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, except in the case of Emergency Services.

• Care for conditions that state or local law requires to be treated in a public facility, including but not limited to, mental illness commitments.

• Charges for telephone consultations or costs associated with completion of a claim form.

• Charges incurred outside of the United States if the Member traveled to such location to obtain Medical Services, drugs, or supplies, or such services, drugs or supplies are unavailable or illegal in the United States.

• Charges, expenses, or costs in excess of UCR.

• Charges, expenses, or costs applied toward satisfaction of any applicable Deductible, Coinsurance, or Copayment amounts.

• 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 including reconstruction following mastectomy, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.

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

• Court ordered services, or those required by court order as a condition of parole or probation.

• Custodial Care.

• Dental services, including but not limited to, services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, dental services related to the gums, apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, alveoectomy, augmentation and vestibuloplasty treatment of periodontal disease, false teeth, prosthetic restoration of dental implants, and dental implants. This exclusion does not include bony impacted teeth, bone fractures, removal of tumors, and orthodontogenic cysts. In addition, subject to preauthorization by HMO, this exclusion does not apply to anesthesia or Hospital services performed for an inpatient or outpatient dental procedure on Members, including infants, exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result; Members demonstrating dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy; extremely uncooperative, fearful, anxious or uncommunicative children or adolescents with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity; and Members who have sustained extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.
• 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 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;
3. HMO has determined that available scientific evidence demonstrates that the drug is effective or the drug shows promise of being effective for the disease or
4. in which the off-label uses are to treat cancer and HIV/AIDS.

• Hair analysis.

• Hearing aids, including charges for examinations or adjustments.

• Home births.

• Home uterine activity monitoring.

• Household equipment, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, whirlpool or swimming pools, exercise and massage equipment, central or unit air conditioners, air purifiers, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a Member’s house or place of business, and adjustments made to vehicles.

• Hypnotherapy, except when specifically approved by HMO.

• Implantable drugs.

• Immunizations obtained for the purpose of travel.

• 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, the costs for donor egg program or gestational carriers, in vitro fertilization procedures, gamete intra fallopian transfer (GIFT), zygote intra fallopian transfer (ZIFT), Infertility supplies.
• Military service related diseases, disabilities or injuries for which the Member is legally entitled to receive treatment at government facilities and which facilities are reasonably available to the Member.

• Missed appointment charges.

• Non-medically necessary services, including but not limited to, those services and supplies:
  1. which are not consistent with generally accepted standards of medical practice;
  2. that are not clinically appropriate in terms of type, frequency, extent, site and duration;
  3. which are not demonstrated through scientific evidence to be effective in improving health outcomes;
  4. that are not representative of “best practices” in the medical profession; and
  5. that are not primarily for the convenience of the Member or Physician or other health care Provider.

• Outpatient supplies, including but not limited to, medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings, and reagent strips. This exclusion does not apply to those supplies covered under the diabetic supplies benefits as described in the Covered Benefits section of this Rider.

• 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 Precertified by HMO.

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

• Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling, and sex therapy.

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

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

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

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

• Services 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 Rider.

- 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 Rider.

- 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), not
     including the off-label use for treatment of cancer, HIV/AIDS;
  2. needles, syringes and other injectable aids, with the exception of those supplies covered
     under the diabetic supplies benefits as described in the Covered Benefits section of this
     Rider;
  3. drugs related to the treatment of non-covered services; and
  4. drugs related to the treatment of Infertility, 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
  Hospital owned or operated by any federal, state or other governmental entity, except to the extent
  required by applicable laws.

- Treatment of the underlying causes of mental retardation, defects, and deficiencies, including the
day to day management of mental retardation. 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 Rider or as required by state law.
• Treatment of occupational injuries and occupational diseases, including those injuries that arise out of (or in the course of) any work for pay or profit, or in any way results from a disease or injury which does. If a Member is covered under a workers' compensation law or similar law, and submits proof that the Member is not covered for a particular disease or injury under such law, that disease or injury will be considered "non-occupational" regardless of cause.

• Weight reduction programs, or dietary supplements.

• Vision care services and supplies, including but not limited to, orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision), charges for examinations to determine the need for (or change of) eyeglasses or lenses of any type except initial replacements for loss of the natural lens, eye surgery such as radial keratotomy when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness), or astigmatism (blurring), or exams for the correction of vision and radial keratotomy eye surgery to improve visual acuity.

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

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

• Coverage of a non-Member donor in a transplant procedure unless the recipient of the transplant is a Member. In the event an HMO Member is the recipient, coverage will be provided under this Rider for a non-Member donor to the extent benefits are unavailable from any other source.

• Orthotics.

• Outpatient prescription or non-prescription drugs and medicines.

• Preventive care, subject to the services and limits, if any, listed on the non-referred Schedule of Benefits.

• Family planning services.

B. Limitations.

• In the event there are 2 (two) or more alternative Medical Services covered under this Rider 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.

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

TERMINATION OF COVERAGE

A Member’s coverage will be terminated in accordance with the Termination Provisions of the HMO Certificate of Coverage.

CONTINUATION AND CONVERSION
A Member is entitled to the Continuation and Conversion provisions as described in the HMO Certificate of Coverage.

**GRIEVANCE PROCEDURE**

The procedures described in the HMO Certificate of Coverage govern complaints, grievances, and grievance appeals made or submitted by Members regarding coverage under this Rider.

**EXTERNAL REVIEW**

A Member is entitled to the External Review provisions as described in the HMO Certificate of Coverage.

**COORDINATION OF BENEFITS**

The benefits provided under this Rider will be subject to Coordination of Benefits as described in the HMO Certificate of Coverage.

**THIRD PARTY LIABILITY AND RIGHT OF RECOVERY**

HMO may recover the full cost of all benefits provided by HMO under this Rider as described in the Third Party Liability and Right of Recovery section of the HMO Certificate of Coverage.

**RESPONSIBILITY OF MEMBERS**

Refer to the Responsibility of Members section of the HMO Certificate of Coverage.

**GENERAL PROVISIONS**

A. **Identification Card.** The identification card issued by HMO to Members pursuant to this Rider is for identification purposes only. Possession of a HMO identification card confers no right to services or benefits under this Rider, and misuse of such identification card may be grounds for termination of Member’s coverage pursuant to the Termination of Coverage section of this Rider. 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 Rider, the holder of the card must be a Member on whose behalf all applicable Premium charges under this Rider have been paid. Any person receiving services or benefits which such person is not entitled to receive pursuant to the provisions of this Rider 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 Rider shall be terminated immediately, subject to the Grievance Procedure in this Rider.

B. **Reports and Records.** HMO is entitled to receive from any Provider of services to Members, information reasonably necessary to administer this Rider subject to all applicable confidentiality requirements as defined in the General Provisions section of this Rider. By accepting coverage under this Rider, the Subscriber, for himself or herself, and for all Covered Dependents covered hereunder, authorizes each and every Provider who renders services or provides supplies 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 Provider. If the Provider (after a second 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 Provider, nor HMO, will have further responsibility to provide any of the benefits available under this Rider for treatment of such condition or its consequences or related conditions. HMO will provide written notice to Member of a decision not to provide further benefits for a particular condition. This decision is subject to the Grievance Procedure in this Rider. 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, subject to the following sentence. A Member’s right to receive payment for benefits will be assigned to a Provider, unless the Member provides evidence that the Member has already paid the Provider.

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

F. Independent Contractor Relationship.

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

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

3. Participating Physicians and Non-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 or Non-Participating Physicians.

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

H. Confidentiality. Information contained in the medical records of Members and information received from any Provider incident to the provider-patient relationship shall be kept confidential in accordance with applicable law. Information may be used or disclosed by HMO when necessary for a Member’s care or treatment, the operation of HMO and administration of this Rider, or other activities, as permitted by applicable law. For other purposes, information may be disclosed only with the consent of the Member. Members can obtain an up-to-date copy of HMO’s Notice of Information Practices by calling the Member Services toll-free telephone number listed on the Member’s identification card.
I. **Incontestability.** In the absence of fraud, all statements made by a **Member** shall be considered representations and not warranties, and no statement shall be the basis for voiding coverage or denying a claim after the **Group Policy** has been in force for 2 years from its effective date, unless the statement was material to the risk and was contained in a written application.

J. This **Rider** 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**.

K. **Contract Holder** hereby makes HMO coverage available to persons who are eligible under the Eligibility section of this **Rider** and the Eligibility and Enrollment section of the **HMO Certificate of Coverage**. However, this **Rider** 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**.

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

M. No agent or other person, except an authorized representative of **HMO**, has authority to waive any condition or restriction of this **Rider**, 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 **Rider** shall be valid unless evidenced by an endorsement to it signed by an authorized representative of **HMO**.

N. The Open Access Health Network Option Program contract is a dual contract, consisting of the **HMO Group Agreement**, and the **HMO Group Policy**. The **HMO Group Agreement** consists of the Group Agreement, Certificate of Coverage, Schedule of Benefits, any riders, and any amendments, endorsements, inserts, or attachments. The **HMO Group Policy** consists of the Group Insurance Policy, Group Insurance Certificate, Schedule of Benefits, and any amendments, riders, endorsements, inserts, or attachments.

This **Rider**, including the non-referred Schedule of Benefits, any riders, and any amendments, endorsements, inserts, or attachments, is part of a dual certificate, to be used in conjunction with the **HMO Certificate of Coverage**, which is made up of the **HMO Certificate of Coverage**, Schedule of Benefits, any riders, and any amendments, endorsements, inserts, or attachments. These documents constitute the entire certificate between the parties hereto pertaining to the subject matter hereof and supersedes all prior and contemporaneous arrangements, understandings, negotiations and discussions of the parties with respect to the subject matter hereof, whether written or oral; and there are no warranties, representations, or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth in this **Rider**. No supplement, modification or waiver of this **Rider** shall be binding unless executed in writing by authorized representatives of the parties.

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

P. **Proof of Loss and Claims Payment.**

1. **Proof of Loss:** Written proof of loss must be furnished to **HMO** within 90 days after a **Member** incurs **Covered Benefits**. Failure to furnish the proof of loss within the time required will not invalidate nor reduce any claim if it is not reasonably possible to give the proof of loss within 90 days, provided the proof of loss is furnished as soon as reasonably possible. However, except in the absence of legal capacity of the claimant, the proof of loss may not be furnished later than one year from the date when the proof of loss was originally required. A proof of loss form may be obtained from **HMO** or the **Contract Holder**. If the **Member** does not receive such form before the expiration of 15 working days after **HMO** receives the request, the **Member** shall be deemed to have complied with the requirements of this **Rider** upon submitting within the time fixed in this **Rider** written proof covering the occurrence, character and extent of the loss for which claim is made.
2. **Time for Payment of Claim:** Benefits payable under this Rider will be paid promptly after the receipt by HMO of satisfactory proof of loss. If any portion of a claim is contested by HMO, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss by HMO.

3. **Payment of Claims:** All or any portion of any indemnities provided by the Rider on account of Hospital, nursing, medical or surgical services shall be paid to the Provider rendering such services; but it is not required that the service be rendered by a particular Hospital or person. Any payment made by HMO in good faith pursuant to this provision will fully discharge HMO’s obligation to the extent of the payment. Claims payment by HMO is subject to the plans’ Grievance Procedure and External Review provisions. The Member may request that payments not be made pursuant to this provision. The request must be made in writing and must be given to HMO not later than the time of filing proof of loss. Payment made prior to receipt of the Member’s written request at HMO’s principal executive office will be deemed to be payment made in good faith.

The Member shall be responsible for the payment of all charges for any service or supply in excess of the UCR charges or otherwise not covered by this Rider.

Q. **Time Limitations on Service.** To be eligible for consideration as a Covered Benefit, any service or supply sought or received by a Member must be billed to and received by HMO no later than 12 months after the date the service was provided unless it is shown to have not been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible.

**DEFINITIONS**

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

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

- **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.

- **Continuous Period of Disability.** Any and all successive Hospital stays unless HMO receives satisfactory evidence that a successive Hospital stay:
  - is due to causes not related to those of the earlier stay;
  - occurs after full recovery from the causes of the earlier Hospital stay; or
  - the later Hospital stay occurs after the Member has completed a period of 90 days without a Hospital confinement.

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

- **Contract Year.** A period of 1 year commencing on the Contract Holder’s Effective Date of Coverage, or the anniversary of that date, and ending at 12:00 midnight on the last day of the succeeding 1 year period.

- **Coinsurance.** The portion of Covered Expenses which a Member must pay for care, after first meeting a Deductible amount. A Member does not have to pay Coinsurance after the Member reaches the individual and family Maximum Out-of-Pocket Limits, if any, as listed on the non-referred Schedule of Benefits.
• **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 the HMO Certificate of Coverage for a description of the Coordination of Benefits provision.

• **Copayment.** The specified dollar amount or percentage required to be paid by or on behalf of a Member in connection with benefits, if any, as set forth on the non-referred Schedule of Benefits.

• **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 Benefits.** Those **Medically Necessary Services** and supplies set forth in this **Rider**, which are covered subject to all of the terms and conditions of the **Group Policy** and **Rider**.

• **Covered Dependent.** Any person in a **Subscriber’s** family who meets all applicable eligibility requirements as described in the HMO Certificate of Coverage and on the HMO Schedule of Benefits, has enrolled in HMO, and is subject to **Premium** requirements set forth in the Premiums section of the **Group Policy**.

• **Covered Expenses.** The **UCR** rate charged for **Covered Benefits** recognized under this **Rider** as eligible for inclusion in calculating reimbursement.

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

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

- **Deductible.** The first payments up to a specified dollar amount which a Member must make in the applicable calendar year for Covered Benefits.

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

- **Durable Medical Equipment (DME).** Equipment, as determined by HMO, which is a) made for and mainly used in the treatment of a disease or injury; b) made to withstand prolonged use; c) suited for use while not confined as an inpatient in the Hospital; d) not normally of use to persons who do not have a disease or injury; e) not for use in altering air quality or temperature; and f) not for exercise or training.

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

- **Emergency Services.** 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.

- **Generic Prescription Drug(s)** - Prescription drugs and insulin, whether identified by its chemical, proprietary, or non-proprietary name, that is 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.

- **Group Policy.** The Group Policy between HMO and the Contract Holder, including the Group Application, this Rider, including the non-referred Schedule of Benefits, any riders, and any amendments, endorsements, inserts, or attachments, as subsequently amended by operation of law and as filed with and approved by the applicable public authority.
• **Health Professional(s).** A **Physician** or other professional who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides **Medical Services** which are within the scope of the individual’s license or certificate.

• **Health Maintenance Organization (HMO).** A **Health Maintenance Organization** as defined in the HMO Certificate of Coverage which provides the **Referred HMO Benefits** under this program.

• **HMO Benefits.** The benefits covered under the HMO Group Agreement and Certificate of Coverage.

• **HMO Primary Care Physician.** An **HMO 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 under the HMO Certificate of Coverage.

• **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 **Providers** as an alternative to hospitalization, and coordinated and **Precertified** by HMO.

• **Hospice Care Agency.** An agency or organization which:

  1. has **Hospice Care** available 24 hours a day;
  2. meets all licensing or certification standards set forth by the jurisdiction where it is located;
  3. provides skilled nursing services; medical social services; psychological and dietary counseling; and bereavement counseling for the immediate family;
  4. provides or arranges for other services which will include services of a **Physician**; physical or occupational therapy; part-time home health aide services which mainly consist of caring for **terminally ill** persons; and inpatient care in a facility when needed for pain control and acute and chronic symptom management;
  5. has personnel which include at least one **Physician**; one R.N. one licensed or certified social worker employed by the Agency; and one pastoral or other counselor;
  6. establishes policies governing the provision of **Hospice Care**;
  7. assesses the patient's medical and social needs;
  8. develops a **Hospice Care** program to meet those needs;
  9. provides an ongoing quality assurance program. This includes reviews by **Physicians**, other than those who own or direct the Agency;
  10. permits all area medical personnel to utilize its services for their patients;
  11. keeps a medical record on each patient;
  12. utilizes volunteers trained in providing services for non-medical needs; and
  13. has a full-time administrator.
• **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. Hospice Care service includes, but is not limited to: Physician services; nursing care; respite care; medical and social work services; counseling services; nutritional counseling; pain and symptom management; medical supplies and durable medical equipment; occupational, physical or speech therapies; volunteer services; Home Health care services and bereavement services.

• **Hospice Facility.** A facility, or distinct part of one, which:
  1. mainly provides inpatient Hospice Care to terminally ill individuals;
  2. charges its patients;
  3. meets all licensing or certification standards set forth by the jurisdiction where it is located;
  4. keeps a medical record on each patient;
  5. provides an ongoing quality assurance program; this includes reviews by Physicians other than those who own or direct the facility;
  6. is run by a staff of Physicians; at least 1 such Physician must be on call at all times;
  7. provides, 24 hours a day, nursing services under the direction of a R.N; and
  8. has a full-time administrator.

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

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

• **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.

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

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

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

• **Medically Necessary, Medically Necessary Services, or Medical Necessity.** To be Medically Necessary, the service or supply must: (i) be consistent with generally accepted standards of medical practice; (ii) be clinically appropriate in terms of type, frequency, extent, site and duration; (iii) be demonstrated through scientific evidence to be effective in improving health outcomes; (iv) be
representative of “best practices” in the medical profession; and (v) be not primarily for the convenience of the Member or Physician.

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

- **Mental or Behavioral Condition(s).** 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.

- **Non-Participating Provider(s).** A Provider not designated as an HMO Participating Provider or such other Provider not part of the HMO.

- **Non-Referred Benefits.** Covered Benefits under this Certificate received from Non-Participating Providers without a prior Referral issued by the Member’s HMO Primary Care Physician.

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

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

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

- **Participating Provider(s).** A Provider designated as an HMO Participating Provider or such other Providers as HMO determines to be part of its network.

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

- **Precertification, Precertify, Precertified.** A certification from HMO that a Member must obtain prior to receiving any of the services that are identified by this Rider as needing Precertification in order to receive unreduced benefits.

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

- **Prescription Drugs.** Drugs and medicines which require a prescription by a Physician, licensed to prescribe federal legend Prescription Drugs or medicines, to dispense and are approved by the U.S. Food and Drug Administration for general use in treating the illness or injury for which they are prescribed.
• **Primary Care Physician (PCP).** A 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, recommends Specialist care, and maintains continuity of patient care.

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

• **Referral.** Specific directions or instructions from a Member’s HMO PCP, in conformance with HMO’s policies and procedures, that direct a Member to an HMO Participating Provider for Medically Necessary care under the HMO Certificate of Coverage.

• **Referred Benefits.** Covered Benefits under the HMO Certificate of Coverage received from Participating Providers upon prior Referral issued by the Member’s HMO Primary Care Physician.

• **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.

• **Rider.** This document, including the non-referred Schedule of Benefits, any riders, and any amendments, endorsements, inserts, or attachments which outlines coverage for a Subscriber and Covered Dependents according to the Group Policy.

• **Self-Referral, Self-Referred.** The process whereby a Member receives Covered Benefits under the HMO Certificate of Coverage from Participating Providers without obtaining a prior Referral from the HMO Primary Care Physician.

• **Skilled Care.** Medical care that requires the skills of technical or professional personnel. This does not include 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 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.

• **Subscriber.** A person who first meets all applicable eligibility requirements as described in the HMO Certificate of Coverage and on the HMO Schedule of Benefits, has enrolled in HMO and is covered under the HMO Certificate of Coverage, and is subject to Premium requirements as set forth in the Premiums section of the Group Policy.

• **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.

• **UCR.** The usual, customary and reasonable charge for a Covered Benefit. Only that part of a charge which is usual, customary and reasonable is covered. The usual, customary and reasonable charge for a service or supply is the lowest of:

   1. the Provider’s usual charge for furnishing it; and
2. the charge HMO determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
3. the charge HMO determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In some circumstances, HMO may have an agreement, either directly or indirectly through a third party, with a Provider which sets the rate that HMO will pay for a service or supply. In these instances, in spite of the methodology described above, the usual, customary and reasonable charge is the rate established in such agreement.

In determining the usual, customary and reasonable charge for a service or supply that is unusual; or not often provided in the area; or provided by only a small number of Providers in the area; HMO may take into account factors, such as:

1. the complexity;
2. the degree of skill needed;
3. the type of specialty of the Provider;
4. the range of services or supplies provided by a facility; and
5. the prevailing charge in other areas.

• Urgent Care. Covered Benefits required in order to prevent serious deterioration of a Member’s health that results from an unforeseen illness or injury and receipt of the health care service cannot be delayed.
CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 01, 2016

The Aetna Health Inc. Open Access Health Network Option PROGRAM RIDER is hereby amended as follows:

The Definitions section of the Program Rider is hereby amended to add the following definition:

• **Surgery or Surgical Procedure.** The diagnosis and treatment of injury, deformity and disease by manual and instrumental means, such as cutting, abrading, suturing, destruction, ablation, removal, lasering, introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy), correction of fracture, reduction of dislocation, application of plaster casts, injection into a joint, injection of sclerosing solution, or otherwise physically changing body tissues and organs.
AMENDMENT TO THE OPEN ACCESS HEALTH NETWORK OPTION PROGRAM RIDER

Contract Holder Group Agreement Effective Date: January 01, 2016

The following is added to the General Provisions section of the Open Access Health Network Option Program Rider:

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 Members or persons who become Members. 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 are not insurance. There are no benefits payable to Members nor does HMO compensate Providers for services they may render.

2. **Incentives**: In addition, 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.
Group Agreement Effective Date: January 01, 2016

The Aetna Health Inc. Open Access Health Network Option Program Rider is hereby amended as follows:

1. The following sentences contained in the Calculation; Determination of UCR; Determination of Benefits provision within the Method of Payment: Deductibles, Coinsurance and Copayment section of the Rider are hereby deleted:

   “HMO reserves the right and sole discretion to determine the UCR rate. It is solely within the discretion of HMO to determine when benefits are covered under this Rider.”

   and replaced with:

   “HMO reserves the right to determine the UCR rate. HMO will determine when benefits are covered under this Rider, subject to the applicable Complaint, Appeals or External Review Procedures as described in the HMO Certificate of Coverage.”

2. The following provisions contained under the Limitations section within the Limitation and Exclusions section of the Rider is hereby deleted:

   • “In the event there are 2 (two) or more alternative Medical Services covered under this Rider 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.”

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

   and replaced with the following:

   • “In the event there are 2 (two) or more alternative Medical Services covered under this Rider which in the 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, subject to the applicable Complaint, Appeals or External Review Procedures as described in the HMO Certificate of Coverage.”

   • “Determinations regarding eligibility for benefits, coverage for services, benefit denials and all other terms of this Rider will be determined by HMO, subject to the terms of this Rider and the HMO Certificate and the applicable Complaint, Appeals or External Review Procedures as described in the HMO Certificate.”

3. The following sentence contained within the Custodial Care definition under the Definitions section of the Rider is hereby deleted:

   “Examples of this include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non infected, post operative or chronic conditions, preparation of special diets, supervision of medication which can be self-administered by the
Member, general maintenance care of colostomy or ileostomy, routine services to maintain other service which, in the sole determination of HMO, based on medically accepted standards, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical or paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest cures, convalescent care.”

and replaced with the following:

“Examples of this include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post operative or chronic conditions, preparation of special diets, supervision of medication which can be self-administered by the Member, general maintenance care of colostomy or ileostomy, routine services to maintain other service which, in the determination of HMO, subject to the applicable Complaint, Appeals or External Review Procedures as described in the HMO Certificate of Coverage, 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.”
CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 01, 2016

The Aetna Health Inc. Open Access Health Network Option PROGRAM RIDER is hereby amended as follows:

The Exclusions and Limitations section of the Program Rider 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 Program Rider 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.
(MAINE)

OPEN ACCESS HEALTH NETWORK OPTION PROGRAM RIDER

HIPAA /PORTABILITY AMENDMENT

Contract Holder Group Agreement Effective Date: January 01, 2016

The Aetna Health Inc. (AHI) Rider is hereby amended as follows:

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.
Contract Holder Group Agreement Effective Date: January 01, 2016

The Aetna Health Inc. Open Access Health Network Option Program Rider is hereby amended as follows:

• 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 dollar maximums that may appear in the Schedule of Benefits and Program Rider, including any amendments or Riders, which have been issued to the Member are removed.

• 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 Program Rider, and such Covered Benefits include these dollar maximums, then the maximums are removed from the Schedule of Benefits and Program Rider, 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 Drugs;
• 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 PROGRAM RIDER. MEMBERS SHOULD REFER TO THEIR PROGRAM RIDER 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), pre-authorization rules, and exclusions and limitations that apply to these **Covered Benefits** as indicated in the Schedule of Benefits and **Program Rider**, including any amendments or riders.

- 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.
The Aetna Health Inc. (AHI) Rider 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/jejunosstomy/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 Private Duty Nursing provision under the Covered Benefits section of the Rider and Schedule of Benefits are hereby deleted.

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

**Home Health Benefits.**

The following services are covered for a Homebound Member when provided by a home health care agency. AHI shall not be required to provide home health benefits when AHI 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 Rider and the Outpatient Rehabilitation section of the Schedule of Benefits.

**Important:** Refer to the AHI Procedure section of the Rider for the list of services and supplies which require Precertification.
The Private Duty Nursing exclusion under the Exclusions and Limitations section of the Rider 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 Rider 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).
AMENDMENT TO OPEN ACCESS HEALTH NETWORK OPTION PROGRAM RIDER

Contract Holder Group Agreement Effective Date: January 01, 2016

The Aetna Health Inc. Program Rider is hereby amended as follows:

The dental services exclusion in the Exclusions and Limitations section 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, bony impacted teeth, alveolectomy, augmentation and vestibuloplasty treatment of periodontal disease, false teeth, prosthetic restoration of dental implants, and dental implants. This exclusion does not include bone fractures, removal of tumors, and orthodontogenic cysts. In addition, subject to preauthorization by HMO, this exclusion does not apply to anesthesia or Hospital services performed for an inpatient or outpatient dental procedure on Members, including infants, exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result; Members demonstrating dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy; extremely uncooperative, fearful, anxious or uncommunicative children or adolescents with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity; and Members who have sustained extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.

The following is added to the Vision Care Benefits provision under the Covered Benefits section:

• Routine Eye Examinations, including refraction, 1 exam(s) every 12 Months period.

All other terms and conditions of the Program Rider shall remain in full force and effect except as amended herein.
OPEN ACCESS HEALTH NETWORK OPTION PROGRAM RIDER AMENDMENT

Contract Holder Group Agreement  Effective Date: January 01, 2016

The Aetna Health Inc. Open Access Health Network Option Program Rider is hereby amended as follows:

Subsection E of the HMO Procedures Section of the Rider is deleted and replaced in its entirety as follows:

E.  HMO and Open Access Health Network Option

Benefits received under the HMO Certificate of Coverage, and Non-Referred Benefits that a Member receives under this Rider, do not duplicate each other. A service or supply, which is a covered benefit under the HMO Certificate of Coverage, is not a Covered Benefit under this Rider. Any HMO Benefits that a Member receives under the HMO Certificate of Coverage, and any benefits that a Member receives under this Rider, will be combined when calculating the maximum benefits which a Member is entitled to receive under either Certificate. Benefit limits offset and do not duplicate each other. The benefits provided under this Rider are offered only in conjunction with and as a supplement to HMO Benefits. Any HMO Benefits covered by rider(s), amendment(s) and/or endorsement(s) to the HMO Certificate of Coverage are not part of this Rider and are excluded from coverage hereunder, unless such services are specifically included in the Covered Benefits section of this Rider. This paragraph is not applicable to the Maximum Benefit, if any, for all Services and Supplies listed on the Schedule of Benefits.

Copayments paid by Members for HMO Benefits received under the HMO Certificate of Coverage, including any rider(s), amendment(s) and/or endorsement(s), unless specifically excluded, shall apply in satisfying the Deductible and the Maximum Out-of-Pocket limits under this Rider.

The Method of Payment; Deductibles, Coinsurance and Copayment Section of the Rider is deleted and replaced in its entirety as follows:

METHOD OF PAYMENT: DEDUCTIBLES, COINSURANCE AND COPAYMENT

A Member first must satisfy the Deductible amount, if any, listed on the Schedule of Benefits before Non-Referred Benefits are reimbursed. Amounts paid to satisfy the Deductible amount for Non-Referred Benefits also will be applied to satisfy the Deductible amount for HMO Benefits and amounts paid to satisfy the HMO Deductible also will be applied to satisfy the Deductible amount for Non-Referred Benefits under this Rider. Thereafter, the Member must pay a Coinsurance and/or Copayment portion of the Covered Expenses for Non-Referred Benefits that the Member received.

A.  The Deductible.

A Member will be eligible for reimbursement of Covered Benefits after the Member has satisfied the Deductible amount, if any, specified on the non-referred Schedule of Benefits.

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

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

B. **The Coinsurance.**

After the **Deductible** amount has been satisfied, **HMO** will pay the percentage of the **Recognized Charge** for **Covered Expenses** set forth in the **Covered Benefits** section of this **Rider**.

C. **Charges in Excess of Recognized Charge.**

The **Member** will be responsible for charges in excess of **HMO**'s contractual liability under this **Rider**. Charges by a **Provider** in excess of **Recognized Charge** will not be covered by **HMO** and will not be counted toward the **Member’s Deductible** amount or **Maximum Out-of-Pocket Limit**, if any, shown on the non-referred Schedule of Benefits.

D. **Maximum Out-of-Pocket Limit.**

If a **Member’s Coinsurance** payments and/or **Copayments**, plus the **Deductible** reach the **Maximum Out-of-Pocket Limit** set forth on the non-referred Schedule of Benefits, **HMO** will pay 100% of the **Recognized Charge** for **Covered Benefits** during the remainder of that calendar year, up to the **Maximum Benefit**, if any, listed on the non-referred Schedule of Benefits. Amounts paid by the **Member** to satisfy the **HMO Benefits** Deductible or the **HMO Maximum Out-of-Pocket Limit** set forth in the **HMO Schedule of Benefits** will count towards satisfying the **Maximum Out-of-Pocket Limit** set forth in the **HMO non-referred Schedule of Benefits**, and amounts paid by the **Member** to satisfy the **Deductible** or the **Maximum Out-of-Pocket Limit**, if any, set forth in the **HMO non-referred Schedule of Benefits** will count towards satisfying the **Maximum Out-of-Pocket Limit** set forth in the **HMO Schedule of Benefits**. **Covered Benefits** must be rendered to the **Member** during that calendar year. Charges in excess of **Recognized Charge** and the additional percentage or dollar amount of **Recognized Charge** which a **Member** may pay as a penalty for failure to obtain **Precertification** will not be applied to the **Maximum Out-of-Pocket Limit** and will not be eligible for 100% reimbursement.

E. **Benefit Limitations.**

**HMO** will provide coverage to **Members** up to the **Maximum Benefit** for all Services and Supplies, if any, set forth on the non-referred Schedule of Benefits. **Covered Benefits** applied toward satisfaction of the **Deductible** will be counted toward any applicable visit or day maximums for **Covered Benefits** under this **Rider**.

F. **Calculations; Determination of Recognized Charge; Determination of Benefits.**

A **Member’s** financial responsibility for the costs of care will be calculated on the basis of when the service or supply is provided, not when payment is made. Charges will be pro-rated to account for treatment or portions of stays that occur in more than 1 calendar year. **HMO** reserves the right and sole discretion to determine the **Recognized Charge**. It is solely within the discretion of **HMO** to determine when expenses are covered under this **Rider**.

All other terms and conditions of the **Rider** shall remain in full force and effect except as amended herein.
AETNA HEALTH INC.
(MAINE)

OPEN ACCESS HEALTH NETWORK OPTION PROGRAM RIDER

Contract Holder Group Agreement  Effective Date: January 01, 2016

The Aetna Health Inc. Program Rider is hereby amended as follows:

The Additional Benefits section of the Program Rider is amended to add the following provision:

• Additional Benefits.

• Walk-in Clinic Benefits.

Covered Benefits include unscheduled, non-Medical Emergency illnesses and injuries, services and supplies provided by a Walk-in Clinic. A free-standing health care facility Provider that is a treatment alternative to a Physician’s office for unscheduled, non-Medical Emergency services and supplies and the administration of certain immunizations as appropriate for such Provider. Neither an emergency room, nor the outpatient department of a Hospital, shall be considered a Walk-in Clinic. Services rendered at a Walk-in Clinic for ongoing care are not Covered Benefits.

All other terms and conditions of the Program Rider shall remain in full force and effect except as amended herein.
AETNA HEALTH INC.  
(MAINE)  

NON-REFERRED BENEFITS UNDER THE OPEN ACCESS HEALTH NETWORK OPTION PROGRAM  
MENTAL DISORDERS AND SUBSTANCE ABUSE BENEFITS AMENDMENT  

Contract Holder Group Policy Effective Date: January 01, 2016  

A. The Mental Health Benefits provision shown in the Covered Benefits section of the OPEN ACCESS HEALTH NETWORK OPTION Program Rider is deleted. It is replaced with the Mental Disorders Benefits provision shown below.  

Mental Disorders Benefits.  

A Member is covered for the treatment of the following Mental Disorders through Behavioral Health Providers:  

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

Important: Refer to the AETNA HEALTH INC. Procedure section of this Certificate for the list of services and supplies which require Precertification.  

• Inpatient benefits may be covered for medical, nursing, counseling or therapeutic services in an inpatient, Hospital or non-hospital Residential Treatment Facility, appropriately licensed by the Department of Health or its equivalent. Coverage, if applicable, is subject to the maximums, if any, shown on the Schedule of Benefits.  

Important: Refer to the AETNA HEALTH INC. Procedure section of this Certificate for the list of services and supplies which require Precertification.  

B. The Substance Abuse Benefits provision shown in the Covered Benefits section of the OPEN ACCESS HEALTH NETWORK OPTION Program Rider is deleted. It is replaced with the Substance Abuse Benefits provision shown below.  

Substance Abuse Benefits.  

A Member is covered for the following services and supplies provided by Behavioral Health Providers:  

• Outpatient care benefits are covered for Detoxification. Benefits include diagnosis, medical treatment and medical referral services (including referral services for appropriate ancillary services) for the abuse of or addiction to alcohol or drugs.  

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

Important: Refer to the AETNA HEALTH INC. Procedure section of this Certificate for the list of services and supplies which require Precertification.
Inpatient care benefits are covered for **Detoxification**. Benefits include medical treatment and referral services for **Substance Abuse**. 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.

The **Member** is entitled to medical, nursing, counseling or therapeutic **Substance Abuse Rehabilitation** services in an inpatient, **Hospital** or non-hospital **Residential Treatment Facility**, appropriately licensed by the Department of Health, for alcohol or drug abuse or dependency. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.

**Important:** Refer to the AETNA HEALTH INC. Procedure section of this Certificate for the list of services and supplies which require Precertification.

C. The definition of **Mental or Behavioral Condition(s)** shown in the **Definitions** section of the **OPEN ACCESS HEALTH NETWORK OPTION Program Rider** is deleted. It is replaced with the following definition of **Mental Disorders** as shown below.

**Mental Disorders.**

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

The following conditions are considered a **Mental Disorder** under this plan:

- Anorexia/Bulimia Nervosa.
- Bipolar disorder.
- Major depressive disorder.
- Obsessive compulsive disorder.
- Panic disorder.
- Pervasive Mental Developmental Disorder (including Autism).
- Psychotic Disorders/Delusional Disorder.
- Schizo-affective Disorder.
- Schizophrenia.

D. The following definition of **Psychiatric Physician** is added to the **Definitions** section of the **OPEN ACCESS HEALTH NETWORK OPTION Program Rider**:

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

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of **Substance Abuse** or **Mental Disorders**.
AETNA HEALTH INC.
(MAINE)

AMENDMENT OPEN ACCESS HEALTH NETWORK OPTION PROGRAM RIDER

RECOGNIZED CHARGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 01, 2016

The definition of “UCR”, appearing in the Definitions section of the Certificate is hereby deleted and, all references to “UCR” and “Reasonable Charge,” if any are replaced by Recognized Charge and the following definition is added to the Definitions section of the Certificate:

Recognized Charge. Only that part of a charge which is less than or equal to the Recognized Charge is a Covered Benefit. The Recognized Charge for a service or supply is the lowest of:

- What the provider bills or submits for that service or supply; and
- for professional services and other services or supplies not mentioned below:
  - 105% of the Medicare Allowable Rate; for the Geographic Area where the service is furnished.
- for inpatient charges of hospitals and other facilities:
  - 140% of the Medicare Rate for the Geographic Area where the service is furnished
- for outpatient charges of hospitals and other facilities:
  - 140% of the Medicare Rate for the Geographic Area where the service is furnished

As to prescription drug expenses, the Recognized Charge for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- 110% of the Average Wholesale Price (AWP) or other similar resource. Average Wholesale Price (AWP) is the current average wholesale price of a prescription drug listed in the Facts and Comparisons Medi-Span weekly price updates (or any other similar publication chosen by Aetna).

If Aetna has an agreement with a provider (directly or through a third party) which sets the rate that Aetna will pay for a service or supply, then the Recognized Charge is the rate established in such agreement.

Aetna may also reduce the Recognized Charge by applying Aetna Reimbursement Policies. Aetna Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- the duration and complexity of a service;
- whether multiple procedures are billed at the same time, but no additional overhead is required;
- whether an assistant surgeon is involved and necessary for the service;
- if follow up care is included;
- whether there are any other characteristics that may modify or make a particular service unique; and
- when a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.
Aetna Reimbursement Policies are based on Aetna’s review of: the policies developed for Medicare; the generally accepted standards of medical practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical community or which is otherwise consistent with physician specialty society recommendations; and the views of physicians practicing in the relevant clinical areas. Aetna uses a commercial software package to administer some of these policies.

As used above Medicare Allowable Rates are defined as follows:

Medicare Allowable Rates: Except as specified below, these are the rates established and periodically updated by The Centers for Medicare and Medicaid Services (CMS) for payment for services and supplies provided to Medicare enrollees. Aetna updates its systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate for a particular service, the rate will be based on the same method that CMS uses to set Medicare rates.

**Important Note**

Aetna periodically updates its systems with changes made to the Medicare Allowable Rates.

*What this means to you* is that the **Recognized Charge** is based on the version of the rates that is in use by Aetna on the date that the service or supply was provided.

As used above Aetna Facility Fee Schedule is defined as follows:

Aetna Facility Fee Schedule: The schedule of rates developed by Aetna using Aetna data or experience for out-of-network facility services and supplies provided in the geographic area in which the member receives the service or supply. For purposes of this definition “geographic area” means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines. Aetna reviews and, if necessary, adjusts this schedule periodically.

**Important Note**

HMO periodically updates its systems with changes made to the Aetna Facility Fee Schedule.

*What this means to Members* is that the **Recognized Charge** is based on the version of the rates that is in use by HMO on the date that the service or supply was provided.

**Additional Information**

Aetna’s website www.aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to Aetna Navigator to access the “Estimate the Cost of Care” feature. Within this feature, view our “Cost of Care” and “Member Payment Estimator” tools, or contact our Customer Service Department for assistance.
The Aetna Health Inc. (AHI) Rider is hereby amended as follows:

The Outpatient Rehabilitation Benefits provision under the Covered Benefits section of the Rider is hereby deleted and replaced with the following:

**Rehabilitation Benefits.**

1. Cardiac and Pulmonary Rehabilitation Benefits.
   a. Cardiac rehabilitation benefits are available as part of a Member’s inpatient Hospital stay. A limited course of outpatient cardiac rehabilitation is covered when Medically Necessary following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
   b. Pulmonary rehabilitation benefits are available as part of a Member’s inpatient Hospital stay. A limited course of outpatient pulmonary rehabilitation is covered when Medically Necessary for the treatment of reversible pulmonary disease states.

Important: Refer to the AHI Procedure section of this Rider for the list of services and supplies which require Precertification.

   Coverage is subject to the limits, if any, shown on the Schedule of Benefits. For inpatient rehabilitation benefits for the services listed below, refer to the Inpatient Hospital and Skilled Nursing Facility benefits provision under the Covered Benefits section of this Rider.
   a. Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is coordinated with AHI as part of a treatment plan intended to restore previous cognitive function.
   b. Physical therapy is covered for non-chronic conditions and acute illnesses and injuries.
   c. Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute illnesses and injuries.
   d. Speech therapy is covered for non-chronic conditions and acute illnesses and injuries.

Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.
Important: Refer to the AHI Procedure section of the Rider for the list of services and supplies which require Precertification.
AETNA HEALTH INC.  
(MAINE)  

OPEN ACCESS HEALTH NETWORK OPTION PROGRAM RIDER

Contract Holder Group Agreement Effective Date: January 01, 2016

The Aetna Health Inc. Rider is amended as follows:

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

**Residential Treatment Facility – (Mental Disorders)**

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

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

**Residential Treatment Facility – (Alcoholism and Drug Abuse)**

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

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

OPEN ACCESS HEALTH NETWORK OPTION PROGRAM RIDER AMENDMENT

Contract Holder Group Agreement Effective Date: January 01, 2016

The “Covered Benefits” section of the Aetna Health Inc. OPEN ACCESS HEALTH NETWORK OPTION PROGRAM RIDER is hereby amended to include the following:

• Telemedicine Benefits

Covered benefits include those for telemedicine services. Coverage shall not be denied on the basis that the coverage is provided through telemedicine if the health care service would be covered if it were provided through in-person consultation between the covered person and a health care provider. Coverage is provided for only those services that are medically necessary, subject to the terms and conditions of the OPEN ACCESS HEALTH NETWORK OPTION PROGRAM RIDER for covered health care services provided through in-person consultation.

“Telemedicine”, as it pertains to the delivery of health care services, means the use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment. “Telemedicine” does not include the use of audio-only telephone or facsimile machine or e-mail.
AETNA HEALTH INC.  
(MAINE)

NON-REFERRED BENEFITS UNDER THE OPEN ACCESS HEALTH NETWORK OPTION PRODUCT

SCHEDULE OF BENEFITS

Open Access Health Network Option
PRESIDENT AND TRUSTEES OF BATES COLLEGE
Contract Holder Group Agreement Effective Date: January 01, 2016
Contract Holder Number: 0869807

BENEFITS

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Non-Participating Provider Deductible/Maximums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible Amount</td>
<td></td>
</tr>
<tr>
<td>Individual Deductible</td>
<td>$3,000 per calendar year</td>
</tr>
<tr>
<td>Family Deductible</td>
<td>$6,000 per family per calendar year</td>
</tr>
</tbody>
</table>

The family Deductible is a cumulative Deductible for all family members. The family deductible can be met by a combination of family members with no single individual within the family contributing more than the individual deductible amount.

| Maximum Out-of-Pocket Limit   |                                               |
| Individual Limit              | $4,000 per calendar year                      |
| Family Limit                  | $8,000 per calendar year                      |

The family Maximum Out-of-Pocket Limit is a cumulative Maximum Out-of-Pocket Limit for all family members. The family Maximum Out-of-Pocket Limit can be met by a combination of family members with no single individual within the family contributing more than the individual limit.

| Maximum Benefit               | Unlimited per Member per lifetime             |

Precertification Penalty

(Certain services require Precertification or benefits will be reduced. Please refer to the Open Access Health Network Option Program Rider for services requiring Precertification.)
## OUTPATIENT BENEFITS

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Non-Participating Provider Copayment/Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Physician Services</strong></td>
<td></td>
</tr>
<tr>
<td>Office Hours Visits</td>
<td>50% after Deductible per visit</td>
</tr>
<tr>
<td>After-Office Hours and Home Visits</td>
<td>50% after Deductible per visit</td>
</tr>
<tr>
<td><strong>Specialist Physician Services</strong></td>
<td></td>
</tr>
<tr>
<td>Office Visits</td>
<td>50% after Deductible per visit</td>
</tr>
<tr>
<td>Walk In Clinic Visit</td>
<td>50% after Deductible per visit</td>
</tr>
<tr>
<td><strong>Prenatal care and delivery services provided by the attending Obstetrician.</strong></td>
<td>50% after Deductible per visit</td>
</tr>
<tr>
<td><strong>Outpatient Rehabilitation</strong></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy, Occupational Therapy, and Speech Therapy</td>
<td>50% after Deductible per visit</td>
</tr>
<tr>
<td>60 visits per calendar year</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Facility Visits</strong></td>
<td>50% after Deductible per visit</td>
</tr>
<tr>
<td>Outpatient Facility Visits</td>
<td>The Coinsurance percentage and Deductible apply to all Covered Benefits incurred during a Member’s outpatient visit.</td>
</tr>
<tr>
<td><strong>Diagnostic X-Ray Testing</strong></td>
<td>50% after Deductible per service</td>
</tr>
<tr>
<td>Complex Imaging Services, such as:</td>
<td>50% after Deductible per service</td>
</tr>
<tr>
<td>Magnetic Resonance Imaging (MRI);</td>
<td></td>
</tr>
<tr>
<td>Computerized Axial Tomography (CAT);</td>
<td></td>
</tr>
<tr>
<td>Positron Emission Tomography (PET)</td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic Laboratory Testing</strong></td>
<td>50% after Deductible per service</td>
</tr>
<tr>
<td><strong>Outpatient Emergency Services</strong></td>
<td>50% after Deductible per service</td>
</tr>
<tr>
<td>Hospital Emergency Room or Outpatient Department</td>
<td>Refer to the HMO Schedule of Benefits for coverage.</td>
</tr>
</tbody>
</table>
Important Note: Please note that as these Providers are not Participating Providers and do not have a contract with HMO, the Provider may not accept payment of a Member's cost share (Deductible, Copayment and Coinsurance) as payment in full. A Member may receive a bill for the difference between the amount billed by the Provider and the amount paid by this Plan. If the Provider bills a Member for an amount above the Member's cost share, a Member is not responsible for paying that amount. A Member should send the bill to the address listed on the back of the ID card, and we will resolve any payment dispute with the Provider over that amount. Make sure the Member's ID number is on the bill.

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage Percentage</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Facility</td>
<td>50% after Deductible per visit</td>
<td>The Coinsurance percentage and Deductible apply to all Covered Benefits incurred during a Member’s outpatient visit.</td>
</tr>
<tr>
<td>Ambulance</td>
<td>20% after Deductible per trip</td>
<td></td>
</tr>
<tr>
<td>Outpatient Mental Disorders Visits</td>
<td>50% after Deductible per visit</td>
<td></td>
</tr>
<tr>
<td>Outpatient Substance Abuse Visits</td>
<td>50% after Deductible per visit</td>
<td></td>
</tr>
<tr>
<td>Detoxification</td>
<td>50% after Deductible per visit</td>
<td></td>
</tr>
<tr>
<td>Outpatient Substance Abuse Visits</td>
<td>50% after Deductible per visit</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>50% after Deductible per visit</td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>50% after Deductible per visit</td>
<td>The Coinsurance percentage and Deductible apply to all Covered Benefits incurred during a Member’s outpatient surgery.</td>
</tr>
<tr>
<td>Outpatient Home Health Visits</td>
<td>50% after Deductible per visit</td>
<td>Limited to 3 intermittent visit(s) per day provided by a home health care agency; 1 visit equals a period of 4 hours or less. Maximum of 120 visits calendar year</td>
</tr>
<tr>
<td>Outpatient Hospice Care Visits</td>
<td>50% after Deductible per visit</td>
<td></td>
</tr>
<tr>
<td>Subluxation</td>
<td>50% after Deductible per visit</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>50% after Deductible per item</td>
<td>Precertification required for equipment leased or purchased over $1,500</td>
</tr>
</tbody>
</table>
**Prosthetics**  
Precertification required for equipment purchased over $1,500

**INPATIENT BENEFITS**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Non-Participating Provider Copayment/Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care</td>
<td>50% after Deductible per admission</td>
</tr>
<tr>
<td>Mental Disorders</td>
<td>50% after Deductible per admission</td>
</tr>
<tr>
<td>During a Hospital Confinement</td>
<td>50% after Deductible per admission</td>
</tr>
<tr>
<td>During a Residential Treatment Facility Confinement</td>
<td>50% after Deductible per admission</td>
</tr>
<tr>
<td>Substance Abuse Detoxification and Rehabilitation</td>
<td>50% after Deductible per admission</td>
</tr>
<tr>
<td>During a Hospital Confinement</td>
<td>50% after Deductible per admission</td>
</tr>
<tr>
<td>During a Residential Treatment Facility Confinement</td>
<td>50% after Deductible per admission</td>
</tr>
<tr>
<td>Maternity</td>
<td>50% after Deductible per admission</td>
</tr>
</tbody>
</table>
Skilled Nursing Facility 50% after Deductible per admission

The Coinsurance percentage and Deductible apply to all Covered Benefits incurred during a Member’s inpatient stay.

Maximum of 100 days per calendar year

Hospice Care 50% after Deductible per admission

The Coinsurance percentage and Deductible apply to all Covered Benefits incurred during a Member’s inpatient stay.

Transplant Benefits

Transplant Facility Expense Services 50% after Deductible per admission

Inpatient Care

The Coinsurance percentage and Deductible apply to all Covered Benefits incurred during a Member’s inpatient stay.

ADDITIONAL BENEFITS

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Non-Participating Provider Copayment/Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Gynecological Exam(s)</td>
<td></td>
</tr>
<tr>
<td>1 visit(s) per 365 days</td>
<td>50% per visit</td>
</tr>
<tr>
<td>Mammography</td>
<td>50% after Deductible per visit</td>
</tr>
<tr>
<td>Routine Pap Smear</td>
<td>50% per visit</td>
</tr>
<tr>
<td>Routine Physicals for Children</td>
<td>50% after Deductible per visit</td>
</tr>
<tr>
<td>Copayment for immunizations waived if office visit charge is not made</td>
<td>50% after Deductible per visit</td>
</tr>
<tr>
<td>Routine Physicals for Adults</td>
<td>50% after Deductible per visit</td>
</tr>
<tr>
<td>Copayment for immunizations waived if office visit charge is not made</td>
<td>50% after Deductible per visit</td>
</tr>
<tr>
<td>Routine Prostate Specific Antigen Tests</td>
<td>50% after Deductible per visit</td>
</tr>
<tr>
<td>Well-Child Care and Immunizations</td>
<td>50% after Deductible per visit</td>
</tr>
<tr>
<td>Vision Care</td>
<td></td>
</tr>
<tr>
<td>Eye Examination by a Specialist (including refraction)</td>
<td>50% after Deductible per exam</td>
</tr>
<tr>
<td>as per schedule in the Open Access Health Network Option Program Rider</td>
<td></td>
</tr>
<tr>
<td>(Certain services require Precertification or benefits will be reduced. Please refer to the Group Insurance Certificate for services requiring Precertification.)</td>
<td></td>
</tr>
</tbody>
</table>
For any service or supply that is subject to a maximum visit, day, or dollar limitation such maximums will be reduced by any services or supplies which are covered as Self-Referred and Referred Benefits under the Open Access Health Network Option Product.

Lifetime Maximum Benefit. This is the most that will be payable for any Member in their lifetime.

Covered Benefits applied toward satisfaction of the Deductible will be counted toward any applicable visit or day maximums for Covered Benefits under this Rider.
AETNA HEALTH INC.  
(MAINE)

OPEN ACCESS HEALTH NETWORK OPTION PROGRAM RIDER AMENDMENT

Contract Holder Group Agreement Effective Date: January 01, 2016

The “Covered Benefits” section of the Aetna Health Inc. OPEN ACCESS HEALTH NETWORK OPTION PROGRAM RIDER is hereby amended to include the following:

• **Children's Early Intervention Services Benefit**

  Covered benefits include those for children's early intervention services. “Children's early intervention services”, means services provided by licensed occupational therapists, physical therapists, speech-language pathologists or clinical social workers working with children from birth to 36 months of age with an identified developmental disability or delay as described in the federal Individuals with Disabilities Education Act, Part C, 20 United States Code, Section 1411, et seq. A referral from the child's Primary Care Physician is required.

The "Outpatient Benefits" section of the Non-Referral Schedule of Benefits is amended to include the following:

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Non-Participating Provider or Participating Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Self-Referral</td>
</tr>
<tr>
<td></td>
<td>Copayment/Coinsurance</td>
</tr>
<tr>
<td>Children's Early Intervention Services</td>
<td>50% after Deductible per visit</td>
</tr>
<tr>
<td>Maximum Benefit for each child</td>
<td>$3,200 calendar year, not to exceed $9,600 by the child's 3rd birthday.</td>
</tr>
</tbody>
</table>
Additional Information Provided by
President and Trustees of Bates College

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet-certificate. Your Plan Administrator has determined that this information together with the information contained in your booklet-certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Name of Plan:
President and Trustees of Bates College

Employer Identification Number:
01-0211781

Plan Number:
526

Type of Plan:
Health and Welfare

Type of Administration:
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:

President and Trustees of Bates College
215 College Street
Lewiston, ME 04240
Telephone Number: (207) 786-8271

Agent For Service of Legal Process:

President and Trustees of Bates College
215 College Street
Lewiston, ME 04240

Service of legal process may also be made upon the Plan Administrator

End of Plan Year:
December 31

Source of Contributions:
Employer and Employee

Procedure for Amending the Plan:
The Employer may amend the Plan from time to time by a written instrument signed by the Plan Administrator.
ERISA Rights
As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits
Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage
Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months after your enrollment date in your coverage under this Plan. Contact your Plan Administrator for assistance in obtaining a certificate of creditable coverage.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.
If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

**Statement of Rights under the Newborns' and Mothers' Health Protection Act**

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

**Notice Regarding Women's Health and Cancer Rights Act**

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

1. all stages of reconstruction of the breast on which a mastectomy has been performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. prostheses; and
4. treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

IMPORTANT HEALTH CARE REFORM INFORMATION

Some language changes in response to the federal Patient Protection and Affordable Care Act (PPACA) 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 PPACA.

The following is a summary of the requirements under PPACA.

1. For non-grandfathered plans:
   a. Subject to any applicable age, family history and frequency guidelines, the following preventive services, to the extent they are not already, are covered under the plan at the Preferred Care level benefits only. Preventive services will be paid at 100% per visit and without cost-sharing such as payment percentages; copays; deductibles; and dollar maximum benefits:
      - Items or services with an “A” or “B” rating from the United States Preventive Services Task Force;
      - Immunizations pursuant to the Advisory Committee on Immunization Practices (“ACIP”) recommendations; and
      - Preventive care and screenings that are provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”).
   b. If the plan requires or recommends that you designate a primary care provider, you may select any participating primary care provider who is available to accept you. In addition, you may select any participating pediatrician as your child’s primary care provider, if the provider is available to accept your child.
   c. If your plan requires the referral or authorization from the primary care provider before receiving obstetrical or gynecological care from a participating provider who specializes in obstetrics or gynecological care, this requirement no longer applies. Care includes the ordering of related obstetrical and gynecological items and services that are covered under your plan.
   d. You do not need prior authorization for the treatment of an emergency medical condition, even if the services are provided by a non-participating provider. Care provided by a non-participating provider will be paid at no greater cost to you than if the services were performed by a participating provider. You may receive a bill for the difference between the amount billed by the provider and the amount paid by Aetna. If a non-participating provider bills you directly for an amount beyond your cost share for the treatment of an emergency medical condition, you are not responsible for paying that amount. Please send the bill at the address listed on the back of your member ID card and we will resolve any payment dispute with the provider over the amount. Make sure your member ID number is on the bill.
   e. You have the right to appeal any action taken by Aetna to deny, reduce or terminate the provision or payment of health care services. When we have done this based on the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the service, you have the right to have the decision reviewed by an external review organization.

2. For grandfathered and non-grandfathered plans:
   a. Any overall plan calendar year and lifetime dollar maximums no longer apply.
   b. Any calendar year or annual and lifetime dollar maximum benefit that applies to an "Essential Service" (as required by PPACA and defined by Aetna) for Preferred Care and Non-Preferred Care no longer applies. Essential Services will continue to be subject to any coinsurance; copays; deductibles; other types of maximums (e.g., day and visit maximums); referral and certification rules; and any exclusions and limitations that apply to these types of covered medical expenses under your plan.
   c. If your Plan includes a pre-existing condition limitation provision, including one that may apply to transplant coverage, then this provision will not apply to a person under 19 years of age.
d. The eligibility rules for children 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 solely dependent upon you for support will not apply. **Please Note:** For grandfathered plans only, if your child (under age 26) is eligible for employer based coverage other than through a parent’s plan, then that child may not be eligible to enroll in this Plan. Contact your policyholder for further information.

e. If your coverage under the Policy is rescinded, Aetna will provide you with a 30 day advance written notice prior to the date of the rescission.
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, copays 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 - 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.
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 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 for new plans on or after January 1, 2014, and for non-grandfathered plans that renew on a date on or after January 1, 2014, Aetna is administering medical and outpatient prescription drug coverage in compliance with the following applicable components of the ACA.

The following is a summary of the recent changes under the ACA.

For details on any benefit maximums and the cost sharing under your plan, log onto the Aetna website www.aetna.com, call the Member Services number on the back of your ID card, or refer to the Summary of Benefit and Coverage document you have received.

1. Subject to any allowed applicable age, family history and frequency guidelines for preventive services covered under the plan, (which may be in-network only for plans that use a provider network) the following services are included in those considered preventive:

   • Coverage of comprehensive lactation support and counseling, and the costs of renting or purchasing breastfeeding equipment extended for the duration of breastfeeding.
   • In accordance with the recommendations of the United States Preventive Services Task Force, and when prescribed by a physician:
     i. aspirin for men and women age 45 and over;
     ii. folic acid for women planning or capable of pregnancy;
     iii. routine iron supplementation for asymptomatic children ages 6 to 12 months;
     iv. vitamin D supplementation for men and women age 65 and older;
     v. fluoride supplementation for children from age 6 months through age 5;
     vi. genetic counseling, evaluation and lab tests for routine breast cancer susceptibility gene (BRCA) testing;
     vii. Food and Drug Administration (FDA) approved female over-the-counter contraceptives, and an office visit for contraceptive administration and/or removal of a contraceptive device.

2. Any annual or lifetime dollar maximum benefit that applies to "Essential Health Benefits" (as defined by the ACA and included in the plan) no longer applies. Essential Health Benefits will continue to be subject to any coinsurance, copays, deductibles, other types of maximums (e.g., day and visit maximums), referral and certification rules, and any exclusions and limitations that apply to these types of covered medical expenses under your plan.

3. If your Plan includes a pre-existing condition limitation or exclusion provision, including one that may apply to transplant coverage, then this limitation or exclusion no longer applies.

4. If your Plan includes a waiting or probationary period, (the period of time that must pass before your coverage can become effective), this period of time cannot be greater than 90 days.
Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request FMLA leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.