AETNA HEALTH INC.
(FLORIDA)

GROUP AGREEMENT COVER SHEET

Contract Holder: The Scripps Research Institute

Contract Holder Number: 378525
012
FL04

HMO Referred Benefit Level: CITIZEN PLAN Benefits Package

Effective Date: 12:01 a.m. on January 1, 2010

Term of Group Agreement: The Initial Term shall be: From January 1, 2010 through December 31, 2010
Thereafter, Subsequent Terms shall be: From January 1st through December 31st

Premium Due Dates: The Group Agreement Effective Date and the 1st day of each succeeding calendar month.

Initial HMO Premium Rates:
Single $340.99
Parent & Child $655.12
Parent & Children $655.12
Couple $815.04
Family $1,041.82

Governing Law: Federal law and the laws of Florida

Notice Address for HMO: Aetna Health Inc.
Employer Services Unit - F126
P.O. Box 44129
Jacksonville, FL 32231

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

AETNA HEALTH INC.

By: [Signature]
Gregory S. Martino
Vice President

Contract Holder Name: The Scripps Research Institute
Contract Holder Number: 378525
Contract Holder Locations: 012
Contract Holder Service Areas: FL04
Contract Holder Group Agreement  Effective Date: January 1, 2010
AETNA HEALTH INC.  
(FLORIDA)  

GROUP AGREEMENT

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

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

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

SECTION 1.  DEFINITIONS

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

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

1.2 The terms “HMO”, “Us”, “We” or “Our” mean Aetna Health Inc.

1.3 “Certificate” means the Certificate of Coverage issued pursuant to this Group Agreement.

1.4 “Grace Period” is defined in Section 3.3.

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

1.6 “Party, Parties” means HMO and Contract Holder.

1.7 “Premium(s)” is defined in Section 3.1.

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

1.9 “Term” means the Initial Term or any Subsequent Term.

1.10 Capitalized and bolded terms not defined in this Group Agreement shall have the meaning set forth in the Certificate. In the event of a conflict between the terms of this Group Agreement and the terms of the Certificate, the terms of this Group Agreement shall prevail.
SECTION 2. COVERAGE

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

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

SECTION 3. PREMIUMS AND FEES

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

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

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

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

- A reinstatement fee as set forth in Section 6.4.

3.3 Past Due Premiums and Fees. If a Premium payment or any fees are not paid in full by Contract Holder on or before the Premium Due Date, a late payment charge of 1 ½% of the total amount due per month (or partial month) will be added to the amount due. If all Premiums and fees are not received before the end of a 31 day grace period (the “Grace Period”), this Group Agreement will be automatically terminated pursuant to Section 6.3 hereof.

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

3.4 Prorations. Premiums shall be paid in full for Members whose coverage is in effect on the Premium Due Date or whose coverage terminates on the last day of the Premium period.
Premiums for Members whose coverage is effective on a day other than the first day of the billing month or whose coverage terminates on a day other than the last day of the billing month shall be adjusted as indicated below:

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

3.5 Changes in Premium. We may also adjust the Premium rates and/or the manner of calculating Premiums effective as of any Premium Due Date upon 30 days prior written notice to Contract Holder, provided that no such adjustment will be made during the Initial Terms except to reflect changes in applicable law or regulation or a judicial decision having a material impact on the cost of providing Covered Benefits to Members.

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

SECTION 4. ENROLLMENT

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

- at least once during every twelve month period during the Open Enrollment Period; and
- within 31 days from the date the individual and any dependent becomes eligible for coverage.

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

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

4.3 Eligibility. The number of eligible individuals and dependents and composition of the group, the identity and status of the Contract Holder, the eligibility requirements used to determine membership in the group, and the participation and contribution standards applicable to the group which exist at the Effective Date of this Group Agreement are material to the execution and continuation of this Group Agreement by Us. The Contract Holder shall not, during the term of this Group Agreement, modify the Open Enrollment Period, the waiting period as described on the Schedule of Benefits, or any other eligibility requirements as described in the Certificate and on the Schedule of Benefits, for the purposes of enrolling Contract Holder’s eligible individuals and dependents under this Group Agreement, unless We agree to the modification in writing.
SECTION 5. RESPONSIBILITIES OF THE CONTRACT HOLDER

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

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

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

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

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

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

- until stopped by the Contract Holder;

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

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

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

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

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

5.5 **Continuation Rights and Conversion.** Notify all eligible Members of their right to continue or convert coverage pursuant to applicable law.
5.6 **ERISA Requirements.** Maintain responsibility for making reports and disclosures required by the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), including the creation, distribution and final content of summary plan descriptions, summary of material modifications and summary annual reports.

**SECTION 6. TERMINATION**

6.1 **Termination by Contract Holder.** This Group Agreement may be terminated by Contract Holder as of any Premium Due Date by providing Us with 30 days prior written notice. However, We may in Our discretion accept an oral indication by Contract Holder or its agent or broker of intent to terminate.

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

6.3 **Termination by Us.** This Group Agreement will terminate as of the last day of the Grace Period provided proper notice has been given to Contract Holder within 10 days of the last day of the Grace Period.

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

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

- Upon 45 days written notice to Contract Holder if Contract Holder no longer has any enrollee under the Plan who resides or works in the Service Area;

- Upon 45 days written notice to Contract Holder if Contract Holder fails to meet Our contribution or participation requirements applicable to this Group Agreement (which contribution and participation requirements are available upon request);

- Upon 90 days written notice to Contract Holder, Members and the Department of Insurance (or such shorter notice as may be permitted by applicable law) if We cease to offer the product to which the Group Agreement relates;

- Upon 180 days written notice to Contract Holder, Members and the Department of Insurance (or such shorter notice as may be permitted by applicable law) if We cease to offer coverage in a market in which Members covered under this Group Agreement reside;

- Upon 45 days written notice to Contract Holder for any other reason which is acceptable to the Department of Insurance and consistent with the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) or by applicable federal rules and regulations, as amended.

6.4 **Effect of Termination.** No termination of this Group Agreement will relieve either party from any obligation incurred before the date of termination. When terminated, this Group Agreement and all coverage provided hereunder will end at 12:00 midnight on the effective date of termination. We may charge the Contract Holder a reinstatement fee if coverage is terminated and subsequently reinstated under this Group Agreement. Upon termination, We will provide Members with Certificates of Creditable Coverage which will show evidence of a Member’s prior health coverage with Us for a period of up to 18 months prior to the loss of coverage.
6.5 **Notice to Subscribers and Members.** It is the responsibility of Contract Holder to notify the Members of the termination of the Group Agreement in compliance with all applicable laws. However, We reserve the right to notify Members of termination of the Group Agreement for any reason, including non-payment of Premium. In accordance with the Certificate, the Contract Holder shall provide written notice to Members of their rights upon termination of coverage.

**SECTION 7. PRIVACY OF INFORMATION**

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

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

- provided the certification required by 45 C.F.R. § 164.504(f) and amended Contract Holder’s plan documents to incorporate the necessary changes required by such rule; or

- provided confirmation that the PHI will not be disclosed to the “plan sponsor”, as such term is defined in 45 C.F.R. § 164.501.

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

**SECTION 8. INDEPENDENT CONTRACTOR RELATIONSHIPS**

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

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

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

**SECTION 9. MISCELLANEOUS**

9.1 **Delegation and Subcontracting.** Contract Holder acknowledges and agrees that We may enter into arrangements with third parties to delegate functions hereunder such as utilization management, quality assurance and provider credentialing, as We deem appropriate in Our sole discretion and as consistent with applicable laws and regulations. Contract Holder also acknowledges that Our arrangements with third party vendors (i.e. pharmacy, behavioral health) are subject to change in accordance with applicable laws and regulations.
9.2 **Accreditation and Qualification Status.** We may from time to time obtain voluntary accreditation or qualification status from a private accreditation organization or government agency. We make no express or implied warranty about Our continued qualification or accreditation status.

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

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

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

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

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

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

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

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

- No statement made by Contract Holder or any Member shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing.
- No statement made by Contract Holder shall be the basis for voiding this Group Agreement after it has been in force for two years from its effective date.
9.9 **Assignability.** No rights or benefits under this **Group Agreement** are assignable by **Contract Holder** to any other party unless approved by **HMO.**

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

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

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

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

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

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

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

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

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

CERTIFICATE OF COVERAGE

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

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

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

Certain words have specific meanings when used in this Certificate. The defined terms appear in bold type with initial capital letters. The definitions of those terms are found in the Definitions section of this Certificate.

This Certificate is not in lieu of insurance for Workers' Compensation. This Certificate is governed by applicable federal law and the laws of Florida.

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

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

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

GRACE PERIOD: THIS CERTIFICATE HAS A 31 DAY GRACE PERIOD. THIS PROVISION MEANS THAT IF ANY REQUIRED PREMIUM IS NOT PAID ON OR BEFORE THE DATE IT IS DUE, IT MAY BE PAID DURING THE FOLLOWING GRACE PERIOD. DURING THE GRACE PERIOD, THE CERTIFICATE WILL STAY IN FORCE.

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

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

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

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HMO Procedure

A. Selecting a Participating Primary Care Physician.

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

B. The Primary Care Physician.

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

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

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

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

C. Availability of Providers.

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

D. Changing a PCP.

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

E. Ongoing Reviews.

HMO conducts ongoing reviews of those services and supplies which are recommended or provided by Health Professionals to determine whether such services and supplies are Covered Benefits under this Certificate. If HMO determines that the recommended services and supplies are not Covered Benefits, the Member will be notified. If a Member wishes to appeal such determination, the Member may then
contact HMO to seek a review of the determination. Please refer to the Claim Procedures/Complaints and Appeals /Dispute Resolution section of this Certificate.

F. Pre-authorization.

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

ELIGIBILITY AND ENROLLMENT

A. Eligibility.

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

2. To be eligible to enroll as a Covered Dependent, the Contract Holder must provide dependent coverage for Subscribers, and the dependent must be:
   a. the legal spouse of a Subscriber under this Certificate; or
   b. a dependent unmarried child (including natural, foster, step, legally adopted children, proposed adoptive children, a child under court order, dependents of dependents) who meets the eligibility requirements described in this Certificate and on the Schedule of Benefits.

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

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

B. Enrollment.

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

1. Newly Eligible Individuals and Eligible Dependents.

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

2. Open Enrollment Period.

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

a. Newborn Children.

A newborn child is covered for 31 days from the date of birth. To continue coverage beyond this initial period, the child must be enrolled in HMO within 60 days of the date of birth. If coverage does not require the payment of an additional Premium for a Covered Dependent, the Subscriber must still enroll the child within 60 days of the date of birth.

A newborn of a Covered Dependent, other than the spouse of the subscriber or subscriber, is covered for 18 months from the date of birth. At the end of the 18 month period, coverage for the newborn will be terminated and the Member will not be eligible for conversion. The newborn should be enrolled within 60 days from the date of birth; however, failure to enroll the newborn within this time frame will not result in denial of coverage.

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

b. Adopted Children.

A legally adopted child or a child for whom a Subscriber is a court appointed legal guardian, and who meets the definition of a Covered Dependent, will be treated as a dependent from the date of adoption or upon the date the child was placed for adoption with the Subscriber. “Placed for adoption” means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The placement must take effect on or after the date a Subscriber’s coverage becomes effective.

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

4. Special Rules Which Apply to Children.

a. Qualified Medical Support Order.

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

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

b. Handicapped Dependents.

Coverage for a handicapped dependent who is primarily dependent upon the Subscriber for support and maintenance, and who is 19 years of age or older but incapable of self-support due to mental or physical incapacity, may be continued past the limiting age for a dependent child. The handicap must have commenced prior to the age the handicapped
dependent child lost eligibility. Proof of continuation of the handicap, including a medical examination, must be submitted to HMO upon denial of a claim for the reason of the child's attainment of the age specified on the Schedule of Benefits. This eligibility provision will no longer apply on the date the dependent’s incapacity ends.

5. Notification of Change in Status.

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

6. Special Enrollment Period.

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

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

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

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

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

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

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

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

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

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

d. the eligible individual or eligible dependent enrolls within 31 days of the loss; and
e. there is a life event such as:

i. the marriage or divorce of the Member;

ii. the birth, proposed adoption or adoption of a child of the Member. The effective date of coverage shall be the date of birth for a newborn; or the date of adoption, or placement for adoption, in the case of an adopted child.

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

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

Special Enrollment Period When a New Eligible Dependent is Acquired:

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

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

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

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

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

C. Effective Date of Coverage.

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

Hospital Confinement on Effective Date of Coverage.

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

COVERED BENEFITS

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

To be Medically Necessary, the service or supply must:

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

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

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

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

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

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

• information provided on the Member's health status;

• reports in peer reviewed medical literature;

• reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;

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

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

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

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

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

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

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

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

CERTAIN COVERED MEDICAL SERVICES MAY BE PROVIDED, UNDER THE DIRECTION OF A LICENSED PARTICIPATING PHYSICIAN, BY PHYSICIAN ASSISTANTS, NURSE PRACTITIONERS OR OTHER INDIVIDUALS WHO ARE NOT LICENSED PHYSICIANS.

MEMBERS HAVE THE RIGHT TO A SECOND MEDICAL OPINION IN ANY INSTANCE IN WHICH THE MEMBER DISPUTES HMO’S OR THE TREATING PHYSICIAN’S OPINION OF THE REASONABLENESS OR NECESSITY OF SURGICAL PROCEDURES OR IS SUBJECT TO A SERIOUS INJURY OR ILLNESS.

The second opinion, if requested by a Member, is to be provided by a Physician chosen by the Member who may select a Participating Physician or a Non-Participating Physician located in the same geographical service area of HMO. If a Member elects a Non-Participating Physician to render a second opinion:

1. any diagnostic tests or further Referrals must be coordinated by the Member’s Participating Primary Care Physician and/or HMO; and
2. the Member will be responsible for a Copayment equal to the amount shown in the Schedule of Benefits.

The professional judgment of HMO’s Physician’s concerning the treatment of a Member derived after review of a second opinion shall be controlling as to the treatment obligations of the HMO. Treatment not authorized by the HMO shall be at the Member’s expense.

A. Primary Care Physician Benefits.

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

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

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

d. routine hearing screenings.

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

f. routine vision screenings.

6. Injections, including allergy desensitization injections.

7. Casts and dressings.

8. Health Education Counseling and Information.

9. Child Health Supervision Services for children from birth through age 16, including a physical examination, developmental assessment; anticipatory guidance, appropriate immunizations and laboratory tests as Medically Necessary. Such services and periodic visits shall be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.

B. Diagnostic Services.

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

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

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

Screening mammogram benefits for female Members are provided as follows:

• age 35 to 39, one baseline mammography

• age 40 and older, one routine mammography every year; or

• one or more mammograms a year, based upon a Physician’s recommendation for any woman who is at risk for breast cancer because of a personal or family history of breast cancer, because of having a history of biopsy-proven benign breast disease, because of having a mother, sister, or daughter who has had breast cancer, or because a woman has not given birth before the age of 30.

C. Specialist Physician Benefits.

Covered Benefits include outpatient and inpatient services.

If a Member requires ongoing care from a Specialist, the Member may receive a standing Referral to such Specialist. If PCP in consultation with a HMO Medical Director and an appropriate Specialist determines that a standing Referral is warranted, the PCP shall make the Referral to a Specialist. This standing Referral shall be pursuant to a treatment plan approved by the HMO Medical Director in consultation with the PCP, Specialist and Member.
Member may request a second opinion regarding a proposed surgery or course of treatment recommended by Member’s PCP or a Specialist. Second opinions must be obtained by a Participating Provider and are subject to pre-authorization. To request a second opinion, Member should contact their PCP for a Referral.

D. Direct Access Specialist Benefits.

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

- Direct Access to Dermatologists. Benefits are provided for Members for dermatological services performed by a Participating Dermatologist limited to office visits, minor procedures and testing. The number of visits, if any, is listed on the Schedule of Benefits.

- Routine Gynecological Examination(s) and Open Access to Gynecologists. Routine gynecological visit(s) and pap smear(s). The number of visits, if any, is listed on the Schedule of Benefits. Benefits are provided to female Members for services performed by a Participating gynecologist for diagnosis and treatment of gynecological problems. See the Infertility Services section of this Certificate for a description of Infertility benefits.

- Direct Access to Chiropractors. Benefits are provided for Members for chiropractic services performed by a Participating Chiropractor limited to office visits, minor procedures and testing. The number of visits, if any, is listed on the Schedule of Benefits.

- Direct Access to Podiatrists. Benefits are provided for Members for podiatry services performed by a Participating Podiatrist limited to office visits, minor procedures and testing. The number of visits, if any, is listed on the Schedule of Benefits.

- Routine Eye Examinations, including refraction, as follows:
  1. if Member is age 1 through 18 and wears eyeglasses or contact lenses, 1 exam every 12-month period.
  2. if Member is age 19 and over and wears eyeglasses or contact lenses, 1 exam every 24-month period.
  3. if Member is age 1 through 45 and does not wear eyeglasses or contact lenses, 1 exam every 36-month period.
  4. if Member is age 46 and over and does not wear eyeglasses or contact lenses, 1 exam every 24-month period.

E. Maternity Care and Related Newborn Care Benefits.

Outpatient and inpatient pre-natal and postpartum care and obstetrical services provided by Participating Providers are a Covered Benefit. Services may be provided by Participating nurse-midwives, midwives and/or birth centers if available in HMO’s Service Area. The Participating Provider is responsible for obtaining any required pre-authorizations for all non-routine obstetrical services from HMO after the first prenatal visit.

Coverage is provided for postdelivery care for the Member and her newborn infant. Coverage will include a postpartum assessment and newborn assessment to be provided at the hospital, the attending Physician’s office, an outpatient maternity center or in the Member’s home by a qualified licensed health care professional trained in mother and baby care. The services will include physical assessment of the newborn and mother, and the performance of any Medically Necessary clinical tests and immunizations in keeping with prevailing medical standards which are Covered Benefits under this Certificate.
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.

F. Inpatient Hospital & Skilled Nursing Facility Benefits.

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

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

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

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

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

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

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

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

G. Transplant Benefits.

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.

Covered Benefits include the following when provided by an IOE:

• Inpatient and outpatient expenses directly related to a Transplant.

• Charges for Transplant-related services, including 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.

• Charges made by a Hospital and/or Physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.

• 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.

H. Outpatient Surgery Benefits.

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

I. Substance Abuse Benefits.

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

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

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

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

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

J. Mental Health Benefits.

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

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

2. Inpatient benefits may be covered for medical, nursing, counseling or therapeutic services in an inpatient, Hospital or non-hospital residential facility, appropriately licensed by the Department of Health or its equivalent. Coverage, if applicable, is subject to the maximum number of days, if any, shown on the Schedule of Benefits.
3. Inpatient benefit exchanges are a **Covered Benefit**. When authorized by HMO, 1 mental health inpatient day, if any, may be exchanged for up to 4 outpatient or home health visits. This is limited to an exchange of up to a maximum of 10 inpatient days for a maximum of 40 additional outpatient visits. One inpatient day, if any, may be exchanged for 2 days of treatment in a **Partial Hospitalization** and/or outpatient electroshock therapy (ECT) program in lieu of hospitalization up to the maximum benefit limitation upon approval by HMO.

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

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

1. **Emergency Care:**

   A **Member** is covered for **Emergency Services and Care**, provided the service is a **Covered Benefit**. The determination as to whether an **Emergency Medical Condition** exists shall be made by a **Physician** of the hospital or, as permitted by Florida law, by other appropriate licensed hospital personnel under the supervision of the hospital **Physician**. Coverage shall be provided for screening, evaluation and examination reasonably necessary to determine whether an **Emergency Medical Condition** exists.

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

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

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

2. **Urgent Care:**

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

   **Urgent Care Outside the HMO Service Area.** The **Member** will be covered for **Urgent Care** obtained from a **Physician** or licensed facility outside of the **HMO Service Area** if the **Member** is temporarily absent from the **HMO Service Area** and receipt of the health care 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 care which is provided to a Member after the Emergency Medical Condition or Urgent Care situation has terminated. All follow-up and continuing care must be provided or arranged by a Member’s PCP. The Member must follow this procedure, or the Member will be responsible for payment for all services received.

L. Outpatient Rehabilitation Benefits.

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

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

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

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

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

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

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

M. Home Health Benefits.

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

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

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

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

4. Short-term physical, speech, or occupational therapy is covered. Services are subject to the limitations listed in the Rehabilitation Benefits section of this Certificate.
Coverage is subject to the maximum number of visits, if any, shown on the Schedule of Benefits.

N. Hospice Benefits.

Hospice Care services for a terminally ill Member are covered when 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 Certificate.

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

O. Prosthetic Appliances.

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

P. Injectable Medications Benefit.

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

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

Q. Basic Infertility Services Benefits.

Benefits include only those Infertility services provided to a Member: a) by a Participating Provider to diagnose Infertility; and b) by a Participating Infertility Specialist to surgically treat the underlying cause of Infertility.

R. Diabetic Supplies and Equipment. Subject to the applicable Copayment, coverage is provided for equipment, supplies and education services for the treatment of diabetic conditions and are covered when ordered or prescribed by a Participating Physician and obtained through a Participating Provider.
Coverage also includes diabetes outpatient self-management training and educational services used to treat diabetes as **Medically Necessary**. Such education must be provided under the direct supervision of a **Participating** certified diabetes educator or a **Participating** board-certified endocrinologist.

**S. Osteoporosis**. Coverage is provided for the **Medically Necessary** diagnosis and treatment of osteoporosis for high-risk **Members**, including but not limited to **Members** who: are estrogen-deficient and are at clinical risk for osteoporosis; have vertebral abnormalities, are receiving long-term glucocorticoid (steroid) therapy, have primary hyperparathyroidism, and have a family history of osteoporosis.

**T. Reconstructive Breast Surgery** resulting from a **Mastectomy** is covered. Coverage includes reconstruction of the breast on which the **Mastectomy** is performed including aereolar reconstruction and the insertion of a breast implant; surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed; and **Medically Necessary** physical therapy to treat the complications of **Mastectomy**, including lymphedema.

Coverage is provided for inpatient care following a **Mastectomy** until the completion of the appropriate period of stay for such inpatient care, as determined by the attending **Physician** in consultation with the **Member**. Coverage will also be provided for the number of outpatient follow-up visits as determined to be appropriate by the attending **Physician** after consultation with the **Member**. The outpatient follow-up visit(s) must be conducted by a **Physician**, a physician’s assistant or a registered professional nurse with experience in post-surgical care. In consultation with the **Member**, the attending **Physician**, physician’s assistant or registered professional nurse will determine whether any outpatient follow-up visit(s) will be conducted at home or at the office.

**U. Cleft Lip and Palate Benefits**. Orthodontics, oral surgery, otologic, nutrition services, audiological and speech/language treatment involved in the management of birth defects known as cleft lip or cleft palate or both. This includes both inpatient and outpatient treatment.

**V. Additional Benefits.**

- **General Anesthesia for Dental Care.**

  Coverage is provided for general anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care provided to a **Member** if the **Member** is:

  - under 8 years of age and determined by a licensed dentist and the child’s **Physician** to require necessary dental treatment in a hospital or ambulatory surgical center due to a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or
  
  - an individual who has one or more medical conditions that would create significant or undue medical risk for the individual in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical center.

  Coverage is NOT provided for dental services associated with general anesthesia and associated hospital or ambulatory facility charges except as otherwise provided in this **Certificate** or a rider to this **Certificate**.

- **Subluxation Benefits.**

  Services by a **Participating Provider** when **Medically Necessary** are covered. Services must be consistent with **HMO** guidelines for spinal manipulation to correct a muscular skeletal problem or subluxation which could be documented by diagnostic x-rays performed by an **HMO Participating** radiologist. Coverage is subject to the maximum number of visits, if any, shown on the Schedule of Benefits.
A Copayment, a maximum annual out-of-pocket payment, and a maximum annual benefit may apply to this service. Refer to the Schedule of Benefits attached to this Certificate.

- **Durable Medical Equipment Benefits.**

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

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

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

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

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

**EXCLUSIONS AND LIMITATIONS**

### A. Exclusions.

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

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

- Biofeedback, except as specifically approved by HMO.

- Blood and blood plasma, including but not limited to, provision of blood, blood plasma, blood derivatives, synthetic blood or blood products other than blood derived clotting factors, the collection or storage of blood plasma, the cost of receiving the services of professional blood donors, aphaeresis or plasmapheresis. Only administration, processing of blood, processing fees, and fees related to autologous blood donations are covered.

- Care for conditions that state or local law requires 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.

- 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.
• **Cosmetic Surgery**, or treatment relating to the consequences of, or as a result of, **Cosmetic Surgery**, other than **Medically Necessary Services**. This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty, except when determined to be **Medically Necessary** by an HMO Medical Director, is not covered. This exclusion does not apply to surgery to correct the results of injuries causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.

• Costs for services resulting from the commission 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, including but not limited to, apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, alveolectomy, augmentation and vestibuloplasty treatment of periodontal disease, false teeth, prosthetic restoration of dental implants, and dental implants. This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors, and orthodontogenic cysts.

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

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

This exclusion will not apply with respect to drugs:

1. that have been granted treatment investigational new drug (IND) or Group c/treatment IND status;

2. that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or

3. **HMO** has determined that available scientific evidence demonstrates that the drug is effective or the drug shows promise of being effective for the disease.

• Hair analysis.

• Hearing aids.

• Home births.

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

- Hypnotherapy, except when pre-authorized by HMO.

- Implantable drugs.

- **Infertility** services including but not limited to:
  1. Artificial Insemination 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. Infertility 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. Infertility 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; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
  6. Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g. office, Hospital, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges.
  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 advanced reproductive technology (“ART”) procedures or services related to such procedures, including but not limited to in vitro fertilization (“IVF”), gamete intra-fallopian transfer (“GIFT”), zygote intra-fallopian transfer (“ZIFT”), and intracytoplasmic sperm injection (“ICSI”);
  11. Any charges associated with care required to obtain ART Services (e.g. office, Hospital, ultrasounds, laboratory tests, etc.); and any charges associated with obtaining sperm for any ART procedures.

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

- Missed appointment charges.

- Non-medically necessary services, including but not limited to, those services and supplies:
  1. which are not Medically Necessary, as determined by HMO, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services;
2. that do not require the technical skills of a medical, mental health or a dental professional;

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

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

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

• Orthotics.

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

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

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

• Prescription or non-prescription drugs and medicines, except as provided on an inpatient basis.

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

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

• Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling, and sex therapy.

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

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

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

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

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

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

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

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

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

- Specific injectable drugs, including:
  1. experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the Food and Drug Administration (FDA) and the National Institutes of Health (NIH);
  2. needles, syringes and other injectable aids;
  3. drugs related to the treatment of non-covered services; and
  4. drugs related to the treatment of Infertility, contraception, and performance enhancing steroids.

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

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

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

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

- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, 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.

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

- Family planning services.

- Services related to the care, filling, removal or replacement of impacted teeth.

- Temporomandibular joint disorder treatment (TMJ), including treatment performed by prosthesis placed directly on the teeth. Coverage will be provided for diagnostic or surgical procedures involving the bones or joints of the jaw and facial region if such procedure is Medically Necessary to treat conditions caused by congenital or developmental deformity, disease or injury. Coverage will not be provided for care or treatment of the teeth or gums, for intraoral prosthetic devices, or for surgical procedures for cosmetic purposes.

Limitations.

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

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

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

TERMINATION OF COVERAGE

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

A. Termination of Subscriber Coverage.

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

1. employment terminates;

2. the Group Agreement terminates;

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

B. Termination of Dependent Coverage.

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

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

C. Termination For Cause.

HMO may terminate coverage for cause:

1. subject to the Claim Procedures/Complaints and Appeals/Dispute Resolution section described in this Certificate, upon 45 days advance written notice, if the Member is unable to establish or maintain, after repeated attempts, a satisfactory physician-patient relationship with a Participating Provider. Notice shall be given by certified mail and return receipt requested. At the effective date of such termination, prepayments received by HMO on account of such terminated Member or Members for periods after the effective date of termination shall be refunded to the Contract Holder.

2. upon 45 days advance written notice, for misuse of the HMO identification membership card.

3. upon 45 days advance written notice, if the Member refuses to cooperate with HMO as required by the Group Agreement.

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

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

The advance written notice provided by HMO upon termination shall contain the reason(s) for termination of the coverage.

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

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

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

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

CONTINUATION AND CONVERSION

A. COBRA Continuation Coverage.

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

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

1. Minimum Size of Group:

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

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

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

3. Loss of coverage due to:

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

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

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

a. the last day of the 18 month period.

b. the last day of the 36 month period.

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

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

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

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

5. Extensions of Coverage Periods:

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

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

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

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

7. Responsibility to pay Premiums to HMO:

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

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

Florida Statute 627.6692, known as the FLORIDA HEALTH INSURANCE COVERAGE CONTINUATION ACT, which became effective January 1, 1997, requires that employers with fewer than 20 eligible employees offer eligible employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") in certain instances where coverage under the plan would otherwise end. This notice is intended to inform the Member, in a summary fashion, of the Member’s rights and obligations under the continuation coverage provisions of the law. This summary of rights should be reviewed by the Subscriber, the Subscriber’s spouse and Covered Dependents (if applicable), retained with other benefits documents, and referred to in the event that any action is required on the Member’s part.

If the Subscriber is an employee of an employer with fewer than 20 employees and covered by its group health plan, the Subscriber has a right to choose this continuation coverage in the event of:

1. loss of group health coverage because of a reduction in hours of employment, or;
2. the termination of employment (for reasons other than gross misconduct).

If the Member is the covered spouse of an employee, the Member has the right to choose continuation coverage due to loss of group health coverage for any of the following four reasons:

Types of Qualifying Events

(1) The death of the employee;
(2) the termination of the employee's employment (for reasons other than gross misconduct) or a reduction in the employee's hours of employment;
(3) divorce or legal separation from the employee; or
(4) the employee becomes entitled to Medicare.

In the case of a Covered Dependent child of an employee, or covered spouse, he or she has the right to continuation coverage if group health coverage is lost for any of the following six reasons:

(1) The death of the employee;
(2) the termination of the employee's employment (for reasons other than gross misconduct) or a reduction in the employee's hours of employment;
(3) parent’s divorce or legal separation;
(4) the employee becomes entitled to Medicare; or
(5) the dependent ceases to be a "dependent child" under the terms of the group health plan.
(6) The Member also has a right to elect continuation coverage if the Member is covered under the plan as a retiree or spouse or child of a retiree, and loses coverage within one year before or after the commencement of proceedings under Title 11 (bankruptcy) United States Code by the employer from whose employment the covered employee retired.

Under the law, qualified beneficiary has the responsibility to inform HMO of a qualified event. This notification must be made within 30 days of the date of the qualifying event which would cause a loss of coverage.

The notice must be in writing, and include:

(a) the name of the qualified beneficiary;
(b) the date of the qualifying event;
(c) one of the types of qualifying events as listed above;
(d) the name of the employer;
(e) the group health plan number; and
(f) the name and address of all qualified beneficiaries.
When HMO is notified that one of these events has happened, it will in turn notify the Member of the right to choose continuation coverage. Under the law, the Member has 30 days from the date of receipt of the Election and Premium Notice form, to elect continuation coverage. If and when this election is made, return the Election and Premium Notice form with applicable premium to the carrier. Coverage will become effective on the day after coverage would otherwise be terminated.

If the Member does not elect coverage and pays the premium, group health insurance coverage will terminate in accordance with the provisions outlined in the benefits handbook or other applicable plan documents.

If the Member chooses continuation coverage, such coverage will be identical to the coverage provided under the plan to similarly situated employees or family members. The law requires that the Member be afforded the opportunity to maintain continuation coverage for 18 months. However, the law also provides that continuation coverage may be terminated for any of the following reasons:

1. The employer/former employer no longer provides group health coverage to any of its employees;
2. the premium for continuation coverage is not paid by the expiration grace period expiration date, which is 30 days;
3. the Member first becomes, after electing continuation coverage, covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any pre-existing condition; or
4. the Member is approved, after electing continuation coverage, for Medicare.

*Note: A Qualified Beneficiary who is determined under Title II or XVI of the Social Security Act, to have been disabled as of the date of termination of employment or reduction in hours may be eligible to continue coverage for an additional 11 months (29 months total). The Member must notify the HMO within 60 days of receipt of the determination of disability by the Social Security Administration and prior to the end of the 18-month continuation period. The HMO can charge up to 150% of the group rate during the 11-month extension. The qualified beneficiary must notify the HMO within 30 days upon the determination that the qualified beneficiary is no longer disabled under Title II or XVI of the Social Security Act.

The Member does not have to show that he or she is insurable to choose continuation coverage. However, the Member may have to pay up to 115% of the applicable Premium for continuation coverage. The law also requires that, at the end of the 18-month or 29-month continuation coverage period, the Member must be allowed to enroll in an individual conversion health plan provided under the current group health plan.

If the Member has any questions about this, please contact the person or office shown below. Also if the Subscriber has changed marital status or the Subscriber, the Subscriber’s spouse, or any eligible Covered Dependent have changed address, please notify in writing this person or office shown below:

Aetna Health Inc.
P.O. Box 30167
Tampa, FL 33630-3167
Attn: Tom Striano, Stand alone HMO plans or Leisa Ross, CHPA Members

If any covered child is at a different address, please notify HMO in writing so that a separate notice may be sent by the carrier to the separate household.

C. Conversion Privilege.

This subsection does not continue coverage under the Group Agreement. It permits the issuance of an individual health care coverage agreement (conversion coverage) under certain conditions.
Conversion is not initiated by HMO. The conversion privilege set forth in this subsection must be initiated by the eligible Member. The Contract Holder is responsible for giving notice of the conversion privilege in accordance with its normal procedures; however, in the event continuation coverage ceases pursuant to expiration of COBRA benefits as described in the COBRA Continuation Coverage section of this Certificate or the “Continuation under Florida law” section of the Certificate, the Contract Holder shall notify the Member at some time during the 180 day period prior to the expiration of coverage.

Upon notification by the Member to HMO of a request for conversion, HMO shall mail an election and premium notice form, including an outline of coverage for each conversion plan to be offered, within 14 days of receipt of the request. This notice form will provide the Member with information regarding the conversion plans from which the Member may choose to elect their conversion coverage.

1. **Eligibility.**

In the event a Member ceases to be eligible for coverage under this Certificate and has been continuously enrolled for 3 months under HMO, and any group health maintenance contract providing similar benefits which HMO replaces, such person may, within 63 days after termination of coverage under this Certificate, or if termination is a result of failure to pay any required premium, 63 days from the date notice of such termination is mailed to the Contract Holder, convert to individual coverage with HMO, effective as of the date of such termination, without evidence of insurability provided that Member’s coverage under this Certificate terminated for one of the following reasons:

a. Coverage under this Certificate was terminated, and was not replaced with continuous and similar coverage by the Contract Holder within 31 days after termination; or

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

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

d. Continuation coverage ceased under the COBRA Continuation Coverage section of this Certificate or the “Continuation under Florida law” section of the Certificate.

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

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

3. Members who are eligible for Medicare at the time their coverage under this Certificate is terminated are not eligible for conversion.
D. Extension of Benefits While Member is Receiving Inpatient Care.

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

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

E. Continuation of Coverage for a Member Receiving Maternity Benefits

HMO will continue to provide covered services if the Contract is terminated while a Member is pregnant, provided that the pregnancy commenced while the Contract was in effect. This Extension of Benefits shall only: (1) provide covered services that are Medically Necessary to treat medical conditions directly related to the pregnancy; and (2) remain in effect until the earlier to occur of the date that: (a) the Member is no longer pregnant; or (b) the Member has exhausted the covered services available for treatment of pregnancy; or (c) the Member becomes eligible for coverage from another health benefit plan which does not exclude coverage for a preexisting maternity condition.

F. Extension of Benefits Upon Total Disability.

Any Member who is Totally Disabled on the date coverage under this Certificate terminates is covered in accordance with the Certificate, however, no Member is eligible for this extension if termination of the Certificate by HMO was for the one or more of the following reasons:

• fraud or material misrepresentation;
• termination for cause; or
• the Member has relocated outside the HMO Service Area.

This extension of benefits shall only:

1. provide Covered Benefits that are necessary to treat medical conditions causing or directly related to the disability as determined by HMO; and
2. remain in effect until the earlier of the date that:
   a. the Member is no longer Totally Disabled; or
   b. the Member has exhausted the Covered Benefits available for treatment of that condition; or
   c. the Member has become eligible for coverage from another health benefit plan which does not exclude coverage for the disabling condition; or
d. after a period of twelve (12) months in which benefits under such coverage are provided to the Member.

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

CLAIMS PROCEDURES/COMPLAINTS AND APPEALS/DISPUTE RESOLUTION

CLAIM PROCEDURES

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

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

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

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

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

- it is excluded from coverage;

- an HMO limitation has been reached; or

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

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

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>HMO Response Time from Receipt of Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent Care Claim</strong>. A claim for medical care or</td>
<td>As soon as possible but not later than 72 hours.</td>
</tr>
<tr>
<td>treatment where delay could seriously jeopardize the</td>
<td></td>
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<tr>
<td>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></td>
</tr>
<tr>
<td><strong>Pre-Service Claim</strong>. A claim for a benefit that</td>
<td>Within 15 calendar days.</td>
</tr>
<tr>
<td>requires pre-authorization of the benefit in advance of obtaining medical care.</td>
<td></td>
</tr>
<tr>
<td><strong>Concurrent Care Claim Extension</strong>. A request to</td>
<td>If an urgent care claim, as soon as possible but not later than 24 hours. Otherwise, within 15 calendar days.</td>
</tr>
<tr>
<td>extend a course of treatment previously pre-authorized by HMO.</td>
<td></td>
</tr>
<tr>
<td><strong>Concurrent Care Claim Reduction or Termination</strong>.</td>
<td>With enough advance notice to allow the Member to Appeal.</td>
</tr>
<tr>
<td>Decision to reduce or terminate a course of treatment previously pre-authorized by HMO.</td>
<td></td>
</tr>
<tr>
<td><strong>Post-Service Claim</strong>. A claim for a benefit that</td>
<td>Within 30 calendar days.</td>
</tr>
<tr>
<td>is not a pre-service claim.</td>
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</tbody>
</table>

### COMPLAINTS AND APPEALS

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

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

- **Complaint.** A Complaint is an expression of dissatisfaction about quality of care or the operation of the HMO. The Complaint procedure may, if the Member chooses, follow the same path as an Adverse Benefit Determination.

#### A. 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 365 calendar days from the date of the notice.

A Member may also choose to have another person (an authorized representative) make the Appeal on the Member’s behalf by providing the HMO with written consent. However, in case of an urgent care claim or a pre-service claim, a Physician may represent the Member in the Appeal.
The HMO provides for two levels of Appeal of the adverse benefit determination. The Member must complete the two levels of HMO review before bringing a lawsuit against the HMO. If the Member decides to Appeal to the second level, the request must be made in writing within 60 calendar days from the date of the notice. The following chart summarizes some information about how the Appeals are handled for different types of claims.

### HMO Timeframe for Responding to an Adverse Benefit Determination Appeal or Complaint Review

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

A Member and/or an authorized representative may attend the Level Two Appeal hearing and question the representative of HMO 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 a Member is not satisfied with the initial response to a Complaint or chooses to file a written Complaint, the Complaint will be reviewed by HMO following the time frames outlined in the chart above. If a Member chooses to file a written Complaint with HMO, the Complaint must be addressed to Aetna Health Inc., Regional Appeals Unit, 11675 Great Oaks Way, Alpharetta, GA 30022. Telephone: 800-323-9930, toll-free.
B. **External Review.**

At any time in the process a **Member** has a right to request a review of the **HMO**'s decision concerning the **Complaint** or Appeal or complaint by Statewide Provider and Subscriber Assistance Program within 365 days after receipt of the final decision letter, and explanation of how to initiate such a review, and the addresses and toll-free numbers of the agency and the Statewide Provider and Subscriber Assistance Program.

Agency for Health Care Administration  
Fort Knox Building One # 303  
2727 Mahan Drive  
Tallahassee, FL 32308-5403  
Toll-Free Number: 1-888-419-3456.

Florida Statewide Provider and Subscriber Assistance Program  
Building One, Room 301  
2727 Mahan Drive  
Tallahassee, FL 32308  
850-921-5458 or Toll-Free Number: 1-888-419-3456

C. **Record Retention.**

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

D. **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**.

E. **Exhaustion of Process.**

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

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

**DISPUTE RESOLUTION**

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

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

COORDINATION OF BENEFITS

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

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

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

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

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

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

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

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

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

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

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

Medicare. The health insurance provided by Title XVIII of the Social Security Act, as amended. It includes HMO or similar coverage that is an authorized alternative to Parts A and B of Medicare.
Plan(s). Any Plan providing benefits or services by reason of medical or dental care or treatment, which benefits or services are provided by one of the following:

1. Group, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
2. Other prepaid coverage under service plan contracts, or under group or individual practice;
3. Uninsured arrangements of group or group-type coverage;
4. Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans;
5. Medical benefits coverage in group, group-type, and individual automobile “no-fault” and traditional automobile “fault” type contracts;
6. Medicare or other governmental benefits;
7. Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group.

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

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

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

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

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

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

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

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

Order of Benefit Determination.

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

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

B. A Plan that does not contain a COB provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the Contract Holder. Examples of this type of exception are major medical coverages that are superimposed over base plan providing Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.
C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

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

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

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

   a. The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:
      - The parents are married;
      - The parents are not separated (whether or not they ever have been married); or
      - A court decree awards joint custody without specifying that 1 party has the responsibility to provide health care coverage.

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

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

   c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
      - The Plan of the Custodial Parent;
      - The Plan of the spouse of the Custodial Parent;
      - The Plan of the non-custodial parent; and then
      - The Plan of the spouse of the non-custodial parent.

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

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

5. **Longer or Shorter Length of Coverage.** The Plan that covered the person as an employee, Member or Subscriber longer is primary.
6. If the preceding rules do not determine the **Primary Plan**, the **Allowable Expenses** shall be shared equally between the **Plans** meeting the definition of **Plan** under this section. In addition, this **Plan** will not pay more than it would have paid had it been primary.

**Effect On Benefits Of This Certificate.**

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

1. Determine its obligation to pay or provide benefits under its contract;
2. Determine whether a benefit reserve has been recorded for the **Member**; and
3. Determine whether there are any unpaid **Allowable Expenses** during that **Claim Determination Period**.

B. If a **Member** is enrolled in 2 or more **Closed Panel Plans** and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by 1 **Closed Panel Plan**, **COB** shall not apply between that **Plan** and other **Closed Panel Plans**.

**Effect of Medicare on COB.**

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

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

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

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

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

1. solely due to age if this **Plan** is subject to the Social Security Act requirements for **Medicare** with respect to working aged (i.e. generally a plan of an employer with 20 or more eligible employees);
2. due to diagnosis of End Stage Renal Disease, but only during the first 30 months of such eligibility for **Medicare** benefits. But this does not apply if at the start of such eligibility the **Member** was already eligible for **Medicare** benefits and this **Plan’s** benefits were payable on a **Secondary Plan** basis;
3. solely due to any disability other than End Stage Renal Disease; but only if this Plan meets the definition of a large group health plan in the Internal Revenue Code (i.e., generally a plan of an employer with 100 or more eligible employees).

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

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

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

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

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

Multiple Coverage Under This Plan.

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

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

Right to Receive and Release Needed Information.

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

Facility of Payment.

Any payment made under another Plan may include an amount which should have been paid under coverage under this Certificate. If so, HMO may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under this Certificate. HMO will not have to pay that amount again. The term “payment made” means reasonable cash value of the benefits provided in the form of services.

Right of Recovery.

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

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

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

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

The Member and the Member’s representatives further agree to:

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

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

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

D. Pay, as the first priority, from any recovery, settlement or judgment or other source of compensation, any and all amounts due HMO as reimbursement for the full cost of all benefits associated with injuries or illness provided by HMO for which a third 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;

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

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

Any such Right of Recovery provided to **HMO** under this **Certificate** shall not apply or shall be limited to the extent that Florida Statutes or the courts of Florida eliminate or restrict such rights.

**RESPONSIBILITY OF MEMBERS**

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

B. The **Member** shall notify **HMO** immediately of any change of address for the **Member** or any of the **Member’s Covered Dependents**.

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

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

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

**GENERAL PROVISIONS**

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

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

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

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

3. permit copying of the Member’s records by HMO.

C. Refusal of Treatment. A Member may, for personal reasons, refuse to accept procedures, medicines, or courses of treatment recommended by a Participating Provider. If the Participating Provider (after a second Participating Provider’s opinion, if requested by Member) believes that no professionally acceptable alternative exists, and if after being so advised, Member still refuses to follow the recommended treatment or procedure, neither the Participating Provider, nor HMO, will have further responsibility to provide any of the benefits available under this Certificate for treatment of such condition or its consequences or related conditions. HMO will provide written notice to Member of a decision not to provide further benefits for a particular condition. This decision is subject to the Claim Procedures/Complaints and Appeals/Dispute Resolution section in this Certificate. Coverage for treatment of the condition involved will be resumed in the event Member agrees to follow the recommended treatment or procedure.

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

E. Legal Action. No action at law or in equity may be maintained against HMO for any expense or bill unless and until the appeal process has been exhausted, and in no event prior to the expiration of 60 days after written submission of claim has been furnished in accordance with requirements set forth in this Group Agreement. No action shall be brought after the expiration of (5) five years after the time written submission of claim is required to be furnished.

F. Independent Contractor Relationship.

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

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

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

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

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

   b. services rendered by a PCP or Hospital to an enrollee between the date of termination of the Provider Agreement and five business days after notification of the contract termination is mailed to the Member at the Member’s last known address shall continue to be Covered Benefits.
5. **Restriction on Choice of Providers:** Unless otherwise approved by HMO, **Members** must utilize **Participating Providers** and facilities who have contracted with HMO to provide services.

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

H. **Confidentiality.** Information contained in the medical records of **Members** and information received from 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 of treatment, the operation of HMO and administration of this **Certificate**, or other activities, as permitted by applicable law. **Members** can obtain a copy of HMO’s Notice of Information Practices by calling the Member Services toll-free number listed on the **Member’s** identification card.

I. **Limitation on Services.** Except in cases of an **Emergency Medical Condition or Urgent Care**, as provided under the Covered Benefits section of this **Certificate**, services are available only from **Participating Providers**. HMO shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a **Member** from any **Physician, Hospital, Skilled Nursing Facility**, home health care agency, or other person, entity, institution or organization unless prior arrangements are made by HMO.

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

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

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

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

N. No agent or other person, except an authorized representative of HMO, has authority to waive any condition or restriction of this **Certificate**, to extend the time for making a payment, or to bind HMO by making any promise or representation or by giving or receiving any information. No change in this **Certificate** shall be valid unless evidenced by an endorsement to it signed by an authorized representative of HMO.

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

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

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 services 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.

R. Notice of Claim: Written notice of claim must be furnished to HMO within 20 days after the occurrence or commencement of any loss covered by this Certificate, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Member or the beneficiary to HMO at the address indicated on the Member’s Identification Card, or to any authorized agent of HMO with information sufficient to identify the Member, shall be deemed notice to HMO.

S. Proof of Loss: Written proof of loss must be furnished to HMO within 90 days after the Member incurs Allowable Expenses. 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.

T. Time of Payment of Claim: Benefits payable under this Certificate will be paid as soon as possible upon receipt by HMO of satisfactory proof of loss, unless this Certificate provides for periodic payment. 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:

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

• Breast Reconstructive Surgery - Surgery performed as a result of a Mastectomy to reestablish symmetry between the two breasts.

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

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

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

• Copayment. A specified dollar amount or percentage required to be paid by or on behalf of a Member in connection with benefits, if any, as set forth in the Schedule of Benefits. Copayments may be changed by HMO upon 30 days written notice to the Contract Holder.
• **Copayment Maximum.** The maximum annual out-of-pocket amount for payment of **Copayments**, if any, to be paid by a **Subscriber** and any **Covered Dependents**.

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

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

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

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

• **Custodial Care.** Any type of care provided in accordance with Medicare guidelines, including room and board, that a) does not require the skills of technical or professional personnel; b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-hospital **Skilled Nursing Facility** care; or c) is a level such that the **Member** has reached the maximum level of physical or mental function and such person is not likely to make further significant improvement. **Custodial Care** includes, but is not limited to, any type of care where the primary purpose of the type of care provided is to attend to the **Member**’s daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of this include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post operative or chronic conditions, preparation of special diets, supervision of medication which can be self-administered by the **Member**, general maintenance care of colostomy or ileostomy, routine services to maintain other service which, in the sole determination of **HMO**, based on medically accepted standards, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical or paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest cures, convalescent care

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

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

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

- **Emergency Medical Condition.**
  1. A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
     a) Serious jeopardy to the health of a patient, including a pregnant woman or a fetus.
     b) Serious impairment to bodily functions.
     c) Serious dysfunction of any bodily organ or part.
  2. With respect to a pregnant woman:
     a) That there is inadequate time to effect safe transfer to another hospital prior to delivery;
     b) That a transfer may pose a threat to the health and safety of the patient or fetus; or
     c) That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

- **Emergency Services and Care.** Medical screening, examination and evaluation by a Physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a Physician, to determine if an Emergency Medical Condition exists and, if it does, the care, treatment, or surgery for a Covered Benefit by a Physician necessary to relieve or eliminate the Emergency Medical Condition, within the service capability of a Hospital.

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

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

- **Health 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 Florida corporation licensed by the Florida Department of Insurance as a Health Maintenance Organization.

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

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

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

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

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

- **Institute of Excellence™ (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.

- **Interested Parties.** Means Contract Holder and Members, including any and all affiliates, agents, assigns, employees, heirs, personal representatives or subcontractors of an Interested Party.

- **Mastectomy.** The removal of all or part of a breast for Medically Necessary reasons as determined by a licensed Physician.

- **Maximum Out-of-Pocket.** The maximum dollar amount of Member cost sharing that a Member must pay for covered services and supplies. Once the Maximum Out-of-Pocket has been reached, no additional Member cost sharing is required for certain covered services for the remainder of the period. Member cost sharing for certain services may not apply to the Maximum Out-of-Pocket and therefore are not eligible for 100% reimbursement for covered services once the Maximum Out-of-Pocket has been reached. Refer to the Schedule of Benefits for the Maximum Out-of-Pocket.

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

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

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

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

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

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

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

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

- **Open Enrollment Period.** A period of not less than thirty (30) consecutive working days, at least every 18 months, 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.** 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 definition includes podiatrists, osteopaths, chiropractors, nurse midwives, midwives and nurse anesthetists.
• **Premium(s).** The amount the **Contract Holder** or **Member** is required to pay to **HMO** to continue coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

1. the **Member** is a **Subscriber** and is prevented, because of injury or disease, from performing any occupation for which the **Member** is reasonably fitted by training, experience, and accomplishments; or
2. the Member is a Covered Dependent and is prevented because of injury or disease, from engaging in substantially all of the normal activities of a person of like age and sex in good health.

- **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.

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

HOME HEALTH CARE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2010

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

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

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

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

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

Examples where a Member would not be considered homebound are:

1. A Member who does not often travel from home because of feebleness and/or insecurity brought on by advanced age (or otherwise).
2. A wheelchair bound Member who could safely be transported via wheelchair accessible transport.

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

• Skilled Nursing Facility. An institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing Skilled Nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. Skilled Nursing Facility does not include institutions which provide only minimal care, Custodial Care services, ambulatory or part-time care services, or institutions which primarily provide for the care and treatment of mental illness and substance abuse. The facility must qualify as a Skilled Nursing Facility under Medicare or as an institution accredited by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association, the Commission...
on the Accreditation of Rehabilitative Facilities, or as otherwise determined by the health insurer
to meet the reasonable standards applied by any of the aforesaid authorities. Examples of Skilled
Nursing Facilities include Rehabilitation Hospitals (all levels of care, e.g. acute) and portions of a
Hospital designated for Skilled or Rehabilitation services.

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

Home Health Benefits.

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

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

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

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

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

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

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

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

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

REHABILITATION AMENDMENT

Contract Holder Group Agreement  Effective Date: January 1, 2010

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

The Outpatient Rehabilitation Benefits provision under the Covered Benefits section of the Certificate is hereby deleted and replaced with the following:

Rehabilitation Benefits.

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

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


   Coverage is subject to the limits, if any, shown on the Schedule of Benefits. For inpatient rehabilitation benefits for the services listed below, refer to the Inpatient Hospital and Skilled Nursing Facility benefits provision under the Covered Benefits section of this Certificate.

   a. Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is coordinated with HMO as part of a treatment plan intended to restore previous cognitive function.
   b. Physical therapy is covered for non-chronic conditions and acute illnesses and injuries.
   c. Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute illnesses and injuries.
   d. Speech therapy is covered for non-chronic conditions and acute illnesses and injuries.
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.
CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement  Effective Date: January 1, 2010

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

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

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

- **Injectable Medications Benefits.**

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

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

Contract Holder Group Agreement  Effective Date: January 1, 2010

The HMO Certificate of Coverage is hereby amended as follows:

The “External Review” sub-section appearing under the section of the Certificate, entitled, “Claims Procedures/Complaints and Appeals/Dispute Resolution” is hereby deleted and replaced by the following:

B. External Review

At any time in the process a Member has a right to request a review of the HMO’s decision concerning a Complaint or Appeal or complaint by the Subscriber Assistance Program within 365 days after receipt of the final decision letter, and explanation of how to initiate such a review, and the addresses and toll-free numbers of the agency and the Subscriber Assistance Program.

Agency for Health Care Administration
Fort Knox #1, Suite 303
2727 Mahan Drive
Tallahassee, Fl 32308-5403
Toll-Free Number: 1-888-419-3456

Florida Subscriber Assistance Program
2727 Mahan Drive
Fort Knox #1, Suite 339
Tallahassee, Fl 32308
850-921-5458 or Toll-Free Number: 1-888-419-3456
Fax: 850-413-0900
spsap@fdhc.state.fl.us

HMO AMD-COMPL-APPL (SAP)-0704 FL
AETNA HEALTH INC.
(FLORIDA)

NOTICE

Please be advised that performance outcome and financial data is compiled and published by the Agency for Health Care Administration. This information may be obtained electronically by accessing the Agency’s website at www.fdhc.state.fl.us.

Please keep this notice with your HMO plan documents for reference.
AETNA HEALTH INC.  
(FLORIDA)  

HIPAA SPECIAL ENROLLMENT/ PORTABILITY AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2010

The Aetna Health Inc. Certificate is amended as follows:

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

6. Special Enrollment Period.

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

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

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

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

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

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

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

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

Loss of eligibility includes the following:

• a loss of coverage as a result of legal separation, divorce or death;
• termination of employment;
• reduction in the number of hours of employment;
any loss of eligibility after a period that is measured by reference to any of the foregoing;
• termination of HMO coverage due to Member action/ movement outside of the HMO’s service area; and also the termination of health coverage including Non-HMO, due to plan termination;
• plan ceases to offer coverage to a group of similarly situated individuals;
• cessation of a dependent’s status as an eligible dependent;
• termination of benefit package.

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

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

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

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

Special Enrollment Period When a New Eligible Dependent is Acquired:

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

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

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

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

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

The Definition of “Creditable Coverage” is deleted and replaced with the following definition:

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

CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2010

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

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

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

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

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

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

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

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

Contract Holder Group Agreement Effective Date: January 1, 2010  

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

The Subrogation and Right of Recovery provision in the Certificate is hereby deleted and replaced with the following:  

SUBROGATION AND RIGHT OF REIMBURSEMENT  

As used herein, the term “Third Party” means any party that is, or may be, or is claimed to be responsible for injuries or illness to a Member. Such injuries or illness are referred to as “Third Party injuries.” “Responsible Party” includes any parties actually, possibly or potentially responsible for payment of expenses associated with the care or treatment of Third Party injuries.  

If this Plan provides benefits under this Certificate to a Member for expenses incurred due to Third Party injuries, then HMO retains the right to repayment of the full cost of all benefits provided by this Plan on behalf of the Member that are associated with the Third Party injuries. HMO’s rights of recovery apply to any recoveries made by or on behalf of the Member from any sources, including but not limited to: payments made by a Third Party or any insurance company on behalf of the Third Party; any payments or awards under an uninsured or underinsured motorist coverage policy; any Workers’ Compensation or disability award or settlement; medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; and any other payments from a source intended to compensate a Member for Third Party injuries.  

By accepting benefits under this Plan, the Member specifically acknowledges HMO’s right of subrogation. When this Plan provides health care benefits for expenses incurred due to Third Party injuries, HMO shall be subrogated to the Member’s rights of recovery against any party to the extent of the full cost of all benefits provided by this Plan. HMO may proceed against any party with or without the Member’s consent.  

By accepting benefits under this Plan, the Member also specifically acknowledges HMO’s right of reimbursement. This right of reimbursement attaches when this Plan has provided health care benefits for expenses incurred due to Third Party injuries and the Member or the Member’s representative has recovered any amounts from any sources, including but not limited to: payments made by a Third Party or any insurance company on behalf of the Third Party; any payments or awards under an uninsured or underinsured motorist coverage policy; any Workers’ Compensation or disability award or settlement; medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; and any other payments from a source intended to compensate a Member for Third Party injuries. By providing any benefit under Certificate, HMO is granted an assignment of the proceeds of any settlement, judgment or other payment received by the Member to the extent of the full cost of all benefits provided by this Plan. HMO’s right of reimbursement is cumulative with and not exclusive of HMO’s subrogation right and HMO may choose to exercise either or both rights of recovery. By accepting benefits under this Plan, the Member and the Member’s representatives further agree to:
A. Notify HMO promptly and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to Third Party injuries sustained by the Member;

B. Cooperate with HMO, provide HMO with requested information, and do whatever is necessary to secure HMO's rights of subrogation and reimbursement under this Certificate;

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

D. Pay, as the first priority, from any recovery, settlement, judgment, or other source of compensation, any and all amounts due HMO as reimbursement for the full cost of all benefits associated with Third Party injuries provided by this Plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement, and regardless of whether such payment will result in a recovery to the Member which is insufficient to make the Member whole or to compensate the Member in part or in whole for the damages sustained), unless otherwise agreed to by HMO in writing; and

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

F. Serve as a constructive trustee for the benefit of this Plan over any settlement or recovery funds received as a result of Third Party injuries.

HMO may recover the full cost of all benefits provided by this Plan under this Certificate without regard to any claim of fault on the part of the Member, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from HMO's recovery, and HMO is not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by the Member to pursue the Member's claim or lawsuit against any Responsible Party without the prior express written consent of HMO. In the event the Member or the Member's representative fails to cooperate with HMO, the Member shall be responsible for all benefits provided by this Plan in addition to costs and attorney's fees incurred by HMO in obtaining repayment.

RECOVERY RIGHTS RELATED TO WORKERS' COMPENSATION

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

The Recovery Rights will be applied even though:

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

b) No final determination is made that bodily injury or sickness was sustained in the course of or resulted from the Member’s employment;
c) The amount of Workers’ Compensation benefits due to medical or health care is not agreed upon or defined by the Member or the Workers’ Compensation carrier; or

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

By accepting benefits under this Plan, the Member or the Member’s representatives agree to notify HMO of any Workers’ Compensation claim made, and to reimburse HMO as described above.
Please be advised that if you are resident of a continuing care facility or a retirement facility your **Participating Primary Care Physician (PCP)** may refer you to the facility's skilled nursing unit or assisted living facility. Your PCP must find that such care is **Medically Necessary** and it is in your best interest to do so. You must request this and the continuing care facility or a retirement facility must agree to be reimbursed at the negotiated rate with similar providers for the same services or supplies. The facility must meet all guidelines established by the **HMO** related to quality of care, utilization, referral authorization, risk assumption, use of the health maintenance organization's network, and other criteria applicable to providers under contract for the same services and supplies.

Please keep this notice with your **HMO** plan documents for reference.
AETNA HEALTH INC.  
(FLORIDA)  
DISCOUNT PROGRAMS CERTIFICATE OF COVERAGE AMENDMENT 

Contract Holder Group Agreement Effective Date: January 1, 2010

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

The Discount provision appearing in the General Provisions section of the Certificate is hereby deleted and replaced with the following:

Q. Additional Provisions:

1. Discount Arrangements: From time to time, HMO may offer, provide, or arrange for discount arrangements or special rates from certain service Providers such as pharmacies, optometrists, dentist, alternative medicine, wellness and healthy living providers to 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 do not constitute benefits provided under the Group Agreement. There are no benefits payable to Members nor does HMO compensate Providers for services they may render.

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

Contract Holder Group Agreement Effective Date: January 1, 2010

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

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

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

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

HMO will notify the Member in writing, at the time it receives a claim, when an assignment of benefits to a health care Provider will not be accepted.
AETNA HEALTH INC.
(FLORIDA)

DEPENDENT ELIGIBILITY AMENDMENT

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

The Dependent Eligibility section of the Certificate is hereby amended to add the following:

In the event you have a dependent child who meets the following requirements, extended coverage may be requested for a Dependent Child between the ages of 26 and 30. To be eligible for extended coverage, a Dependent must satisfy the following:

- Is unmarried and does not have dependent of his or her own;
- Is a resident of Florida or a Student, and
- Is not eligible for Medicare and is not actually covered under another group or individual health plan.

You must make the request to continue the dependent child's coverage

- When he or she reaches the limiting age, or;
- During the open enrollment period for the group of which the parent is Member on or after October 1, 2008.
AETNA HEALTH INC.
(FLORIDA)

DOMESTIC PARTNER RIDER

Contract Holder Group Agreement Effective Date: January 1, 2010

The Domestic Partner rider for this contract is effective January 1, 2010.

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

a. the legal spouse or domestic partner of a Subscriber under this Certificate, and who, as of the date of enrollment (with respect to a domestic partner):
   
   i. are both of the age of consent in their state of residence;
   ii. are not related by blood in any manner that would bar marriage in their state of residence;
   iii. have a close, committed and monogamous personal relationship;
   iv. have been sharing the same household on a continuous basis for at least 6 months;
   v. have registered as domestic partners where such registration is available;
   vi. is not married to, or separated from, another individual;
   vii. have not been registered as a member of another domestic partnership within the last six months; and
   viii. demonstrates financial interdependence by submission of proof of three or more of the following:

   a) common ownership of real property or a common leasehold interest in such property;
   b) common ownership of a motor vehicle;
   c) joint bank accounts or credit accounts;
   d) designation as a beneficiary for life insurance or retirement benefits, or under the partner's will;
   e) assignment of a durable power of attorney or health care power of attorney; or
   f) such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case

   ix. and is of the same sex as the Subscriber.

   are both members of the same sex in a committed relationship; or we are in a committed relationship and (1) one/or both of us is/are over the age of 62, and (2) one or both of us meet(s) the criteria for Social Security benefits for old-age or aged individuals.

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

PRESCRIPTION PLAN RIDER

Group Agreement Effective Date: January 1, 2010

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

DEFINITIONS

The Definitions section of the Certificate is amended to include the following definitions:

• Brand Name Prescription Drug(s). Prescription drugs and insulin with a proprietary name assigned to it by the manufacturer or distributor and so indicated by MediSpan or any other similar publication designated by HMO or an affiliate. Brand Name Prescription Drugs do not include those drugs classified as Generic Prescription Drugs as defined below.

• Contracted Rate. The negotiated rate between HMO or an affiliate and the Participating Retail or Mail Order Pharmacy. This rate does not reflect or include any amount HMO or an affiliate may receive under a rebate arrangement between HMO or an affiliate and a drug manufacturer for any drugs, including any drugs on the Drug Formulary.

• Drug Formulary. A list of prescription drugs and insulin established by HMO or an affiliate, which includes both Brand Name Prescription Drugs, and Generic Prescription Drugs. This list is subject to periodic review and modification by HMO or an affiliate. A copy of the Drug Formulary will be available upon request by the Member or may be accessed at the pharmacy website, at www.aetna.com.

• Drug Formulary Exclusions List. A list of prescription drugs excluded from the Drug Formulary, subject to change from time to time at the sole discretion of HMO.

• Generic Prescription Drug(s). Prescription drugs and insulin, whether identified by their chemical, proprietary, or non-proprietary name, that are accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by MediSpan or any other similar publication designated by HMO or an affiliate.

• Non-Formulary Prescription Drug(s). A product or drug not listed on the Drug Formulary which includes drugs listed on the Drug Formulary Exclusions List.

• Participating Mail Order Pharmacy. A pharmacy, which has contracted with HMO or an affiliate to provide covered outpatient prescription drugs or medicines, and insulin to Members by mail or other carrier.

• Participating Retail Pharmacy. A community pharmacy which has contracted with HMO or an affiliate to provide covered outpatient prescription drugs to Members.

• Precertification Program. For certain outpatient prescription drugs, prescribing Physicians must contact HMO or an affiliate to request and obtain coverage for such drugs. The list of drugs requiring precertification is subject to change by HMO or an affiliate. An updated copy of the list of drugs requiring precertification shall be available upon request by the Member or may be accessed at the pharmacy website, at www.aetna.com.
• **Step Therapy Program.** A form of precertification under which certain prescription drugs will be excluded from coverage, unless a first-line therapy drug(s) is used first by the Member. The list of step therapy drugs is subject to change by HMO or an affiliate. An updated copy of the list of drugs subject to step therapy shall be available upon request by the Member or may be accessed at the pharmacy website, at www.aetna.com.

**COVERED BENEFITS**

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

A. **Outpatient Prescription Drug Open Formulary Benefit**

**Medically Necessary** outpatient prescription drugs and insulin are covered when prescribed by a Provider licensed to prescribe federal legend prescription drugs or medicines subject to the terms, HMO policies, Exclusions and Limitations section described in this rider and the Certificate. Coverage is based on HMO’s or an affiliate’s determination, in its sole discretion, if a prescription drug is covered. Some items are covered only with pre-authorization from HMO. Items covered by this rider are subject to drug utilization review by HMO and/or Member’s Participating Provider and/or Member’s Participating Retail or Mail Order Pharmacy.

B. Each prescription is limited to a maximum 30 day supply when filled at a Participating Retail Pharmacy or 90 day supply when filled by the Participating Mail Order Pharmacy designated by HMO. Except in an emergency or Urgent Care situation, or when the Member is traveling outside the HMO Service Area, prescriptions must be filled at a Participating Retail or Mail Order Pharmacy. Coverage of prescription drugs may, in HMO’s sole discretion, be subject to the Precertification Program, the Step Therapy Program, or other HMO requirements or limitations.

C. FDA approved prescription drugs are covered when the off-label use of the drug has not been approved by the FDA for that indication, provided that such drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information), or the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer reviewed journal. Coverage of off label use of these drugs may, in HMO’s sole discretion, be subject to the Precertification Program, the Step Therapy Program or other HMO requirements or limitations.

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

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

When a Member obtains an emergency or out-of-area Urgent Care prescription at a non-Participating Retail Pharmacy, Member must directly pay the pharmacy in full for the cost of the prescription. Member is responsible for submitting a request for reimbursement in writing to HMO with a receipt for the cost of the prescription. Reimbursement requests are subject to professional review by HMO to determine if the event meets HMO’s requirements. Upon approval of the claim, HMO will directly reimburse the Member 100% of the cost of the prescription, less the applicable Copayment specified below and any Brand Name Prescription Drug cost differentials as applicable. Coverage for items obtained from a non-Participating pharmacy is limited to items obtained in connection with covered emergency and out-of-area Urgent Care services. Members must access a Participating Retail Pharmacy for Urgent Care prescriptions inside the HMO Service Area.
When a Member obtains an emergency or Urgent Care prescription at any Participating Retail Pharmacy, including an out-of-area Participating Retail Pharmacy, Member will pay to the Participating Retail Pharmacy the Copayment(s), plus the Brand Name Prescription Drug cost differentials where applicable and as described below. Members are required to present their ID card at the time the prescription is filled. HMO will not cover claims submitted as a direct reimbursement request from a Member for a prescription purchased at a Participating Retail Pharmacy except upon professional review and approval by HMO in its sole discretion. Members must access a Participating Retail Pharmacy for Urgent Care prescriptions inside the HMO Service Area.

E. Mail Order Prescription Drugs. Subject to the terms and limitations set forth in this rider, Medically Necessary outpatient Prescription drugs are covered when dispensed by the Participating Mail Order Pharmacy designated by HMO and when prescribed by a Provider licensed to prescribe federal legend prescription drugs. Members are required to obtain prescriptions greater than a 30 day supply from the designated Participating Mail Order Pharmacy. Outpatient prescription drugs will not be covered if dispensed by a Participating Mail Order Pharmacy in quantities that are less than a 31 day supply or more than a 90 day supply (if the Provider prescribes such amounts).

F. Additional Benefits.

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

- **Diabetic Supplies.**

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

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

- **Contraceptives.**

  The following contraceptives and contraceptive devices are covered upon prescription or upon the Participating Physician's order only at a Participating Retail or Mail Order Pharmacy:

  1. Oral Contraceptives.
  2. Diaphragms, 1 per 365 consecutive day period.
  3. Injectable contraceptives, the prescription plan Copayment applies for each vial up to a maximum of 5 vials per calendar year.
  4. Contraceptive patches
  5. Contraceptive rings
  6. Norplant and IUDs are covered when obtained from a Participating Physician. The Participating Physician will provide insertion and removal of the device. An office visit Copayment will apply, if any. A Copayment for the contraceptive device may also apply.

G. **Copayments:**
**Member** is responsible for the **Copayments** specified in this rider. The **Copayment**, if any, is payable directly to the **Participating Retail** or **Mail Order Pharmacy** for each prescription or refill at the time the prescription or refill is dispensed. If the Member obtains more than a 30 day supply of prescription drugs or medicines at the **Participating Retail** or **Mail Order Pharmacy**, not to exceed a 90 day supply, **2 Copayments** are payable for each supply dispensed. The **Copayment** does not apply to the Maximum Out-of-Pocket Limit shown in the Schedule of Benefits for the medical plan, if any.

<table>
<thead>
<tr>
<th>Prescription Drug/Medicine Quantity</th>
<th>Generic Formulary Prescription Drugs</th>
<th>Brand Name Formulary Prescription Drugs</th>
<th>Non-Formulary Prescription Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than a 31 day supply</td>
<td>$10</td>
<td>$25</td>
<td>$50</td>
</tr>
</tbody>
</table>

**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:

1. Any drug which does not, by federal or state law, require a prescription order (i.e., an over-the-counter (OTC) drug) or for which an equivalent over-the-counter product in strength, is available even when a prescription is written, unless otherwise covered by **HMO**.
2. Any drug determined not to be **Medically Necessary** for the treatment of disease or injury unless otherwise covered under this rider.
3. Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by **HMO**.
4. Cosmetic or any drugs used for cosmetic purposes or to promote hair growth, including but not limited to health and beauty aids.
5. Needles and syringes, excluding diabetic needles and syringes.
6. Any medication which is consumed or administered at the place where it is dispensed, or while a **Member** is in a **Hospital**, or similar facility; or take home prescriptions dispensed from a **Hospital pharmacy** upon discharge, unless the pharmacy is a **Participating Retail Pharmacy**.
7. Immunization or immunological agents, including but not limited to, biological sera, blood, blood plasma or other blood products administered on an outpatient basis, allergy sera and testing materials.
8. Drugs used for the purpose of weight reduction (e.g., appetite suppressants), including the treatment of obesity.
9. Any refill in excess of the amount specified by the prescription order. Before recognizing charges, **HMO** may require a new prescription or evidence as to need, if a prescription or refill appears excessive under accepted medical practice standards.
10. Any refill dispensed more than 1 year from the date the latest prescription order was written, or as otherwise permitted by applicable law of the jurisdiction in which the drug is dispensed.
11. Drugs prescribed for uses other than uses approved by the Food and Drug Administration (FDA) under the Federal Food, Drug and Cosmetic Law and regulations, or any drug labeled “Caution: Limited by Federal Law to Investigational Use”, or experimental drugs except as otherwise covered under this rider.
12. Medical supplies, devices and equipment and non-medical supplies or substances regardless of their intended use.
14. Injectable drugs used for the purpose of treating Infertility, unless otherwise covered by HMO.
15. Injectable drugs, except for insulin.
16. Oral and implantable contraceptives and contraceptive devices, unless otherwise covered under this rider.
17. Prescription orders filled prior to the effective date or after the termination date of the coverage provided by this rider.
18. Replacement for lost or stolen prescriptions.
19. Performance, athletic performance or lifestyle enhancement drugs and supplies.
20. Drugs and supplies when not indicated or prescribed for a medical condition as determined by HMO or otherwise specifically covered under this rider or the medical plan.
21. Drugs dispensed by other than a Participating Retail or Mail Order Pharmacy, except as Medically Necessary for treatment of an emergency or Urgent Care condition.
22. Medication packaged in unit dose form. (Except those products approved for payment by HMO).
23. Prophylactic drugs for travel.
24. Drugs recently approved by the FDA, but which have not yet been reviewed by the Aetna Health Pharmacy Management Department and Therapeutics Committee.
25. Drugs for the convenience of Members or for preventive purposes.
26. Drugs listed on the Formulary Exclusions List unless otherwise covered through a medical exception as described in this rider or unless otherwise covered under this rider.
27. Sildenafil citrate, phentolamine, apomorphine and alprostadil in oral, injectable and topical (including but not limited to gels, creams, ointments and patches) forms or any other form used internally or externally. Any prescription drug in oral, topical or any other form that is in a similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes unless otherwise covered under this rider.
29. Smoking cessation aids or drugs.

B. Limitations:

1. A Participating Retail or Mail Order Pharmacy may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.

2. Non-emergency and non-Urgent Care prescriptions will be covered only when filled at a Participating Retail Pharmacy or the Participating Mail Order Pharmacy. Members are required to present their ID card at the time the prescription is filled. A Member who fails to verify coverage by presenting the ID card will not be entitled to direct reimbursement from HMO, and Member will be responsible for the entire cost of the prescription. Refer to the Certificate for a description of emergency and Urgent Care coverage. HMO will not reimburse Members for out-of-pocket expenses for prescriptions purchased from a Participating Retail Pharmacy; Participating Mail Order Pharmacy or a non-Participating Retail or Mail Order Pharmacy in non-emergency, non-Urgent Care situations. HMO retains the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to the Grievance Procedure section(s) 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 payment which applies to the Prescription Drug Deductible Amount, if any, 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.
AETNA HEALTH INC.
(FLORIDA)

AMENDMENT TO THE PRESCRIPTION PLAN RIDER

Contract Holder Group Agreement Effective Date: January 1, 2010

The Aetna Health Inc. Prescription Plan Rider is hereby amended as follows:

The Definition of “Contracted Rate”, appearing in the Definitions section of the Prescription Drug Rider is hereby deleted and, all references to “Contracted Rate” are replaced by “Negotiated Charge” and the following definition is added to the Definitions section of the Prescription Drug Rider:

- **Negotiated Charge.** The compensation amount negotiated between HMO or an affiliate and a Participating Retail Pharmacy, Participating Mail Order Pharmacy, or Specialty Pharmacy Network pharmacy for Medically Necessary outpatient prescription drugs and insulin dispensed to a Member and covered under the Member’s benefit plan. This negotiated compensation amount does not reflect or include any amount HMO or an affiliate may receive under a rebate arrangement between HMO or an affiliate and a drug manufacturer for any drug, including drugs on the Drug Formulary.

The Definitions section of the Prescription Plan Rider is amended to add the following:

- **Self-injectable Drug(s).** Prescription drugs that are intended to be self administered by injection to a specific part of the body to treat certain chronic medical conditions. An updated copy of the list of covered Self-injectable Drugs, designated by HMO as eligible for coverage under this amendment, shall be available upon request by the Member or may be accessed at the HMO website, at www.aetna.com. The list is subject to change by HMO or an affiliate.

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

The Additional Benefits section of the Prescription Plan Rider is amended to include the following benefits:

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

  Food and Drug Administration (FDA) approved Self-injectable Drugs, eligible for coverage under this amendment, are covered when the off-label use of the drug has not been approved by the FDA for that indication, provided that such drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information), or the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer review journal. Coverage of off label use of these drugs may, in HMO’s sole discretion, be subject to the Precertification Program, the Step Therapy Program or other HMO requirements or limitations.

  Member is responsible for the payment of the applicable Copayment for each prescription or refill. The Copayment is specified in the Prescription Plan Rider.
The exclusion for Injectable drugs, except for insulin in the Exclusions and Limitations section of the Prescription Plan Rider is hereby deleted and replaced with the following:

- Injectable drugs, except for insulin and **Self-injectable Drugs**.

Coverage is subject to the terms and conditions of the **Certificate**.
CITIZEN PLAN  
The Scripps Research Institute  
Contract Holder Group Agreement Effective Date: January 1, 2010  
Contract Holder Number: 378525  
Contract Holder Locations: 012  
Contract Holder Service Areas: FL04

**BENEFITS**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Maximums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Out-of-Pocket Limit</td>
<td>$1,500 per Member per calendar year</td>
</tr>
<tr>
<td></td>
<td>$3,000 per family per calendar year</td>
</tr>
</tbody>
</table>

The family **Maximum Out-of-Pocket Limit** is a cumulative **Maximum Out-of-Pocket Limit** for all family members.

**Member** must demonstrate the **Copayment** amounts that have been paid during the year.

**Maximum Benefit**

Unlimited per Member per lifetime

**OUTPATIENT BENEFITS**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Physician Services</strong></td>
<td></td>
</tr>
<tr>
<td>Adult Physical Examination</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Well Child Physical Examination including Immunizations</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Office Hours Visits</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>After-Office Hours and Home Visits</td>
<td>$20 per visit</td>
</tr>
<tr>
<td><strong>Routine Gynecological Exam(s)</strong></td>
<td></td>
</tr>
<tr>
<td>1 visit(s) per 365 day period</td>
<td>$15 per visit</td>
</tr>
<tr>
<td><strong>Specialist Physician Services</strong></td>
<td></td>
</tr>
<tr>
<td>Office Visits</td>
<td>$15 per visit</td>
</tr>
<tr>
<td><strong>First Prenatal Visit</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$15</td>
</tr>
<tr>
<td><strong>Outpatient Rehabilitation</strong></td>
<td></td>
</tr>
<tr>
<td>Treatment over a 60 consecutive day period per incident of illness or injury beginning with the first day of treatment</td>
<td>$15 per visit</td>
</tr>
</tbody>
</table>
Outpatient Facility Visits $15 per visit

Diagnostic X-Ray Testing $15 per visit

Complex Imaging Services, including, but not limited to: Magnetic Resonance Imaging (MRI); Computerized Axial Tomography (CAT); and Positron Emission Tomography (PET) $0 per visit

Mammography $15 per visit

Diagnostic Laboratory Testing $0 per visit

Outpatient Emergency Services Hospital Emergency Room or Outpatient Department $100 per visit

Urgent Care Facility $50 per visit

Ambulance $0 per trip

Dermatological Visits $15 per visit

5 non-referred visits per 365-day period

Outpatient Mental Health Visits Unlimited visits per calendar year $15 per visit

Outpatient Substance Abuse Visits Detoxification $15 per visit/day

Outpatient Substance Abuse Visits Rehabilitation: Unlimited visits per calendar year $15 per visit/day

Outpatient Surgery $0 per visit

Outpatient Home Health Visits Limited to 3 intermittent visit(s) per day provided by a Participating home health care agency; 1 visit equals a period of 4 hours or less. $0 per visit

120 visits per calendar year

Outpatient Hospice Care Visits $0 per visit

Injectable Medications $15 per visit or per prescription or refill
### INPATIENT BENEFITS

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Care</strong></td>
<td>$0 per admission</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>$0 per admission</td>
</tr>
<tr>
<td>Maximum of Unlimited days per calendar year</td>
<td></td>
</tr>
<tr>
<td><strong>Substance Abuse</strong></td>
<td>$0 per admission</td>
</tr>
<tr>
<td>Detoxification</td>
<td></td>
</tr>
<tr>
<td><strong>Substance Abuse</strong></td>
<td>$0 per admission</td>
</tr>
<tr>
<td>Rehabilitation:</td>
<td></td>
</tr>
<tr>
<td>Maximum of Unlimited days per 365 day period</td>
<td></td>
</tr>
<tr>
<td><strong>Maternity</strong></td>
<td>$0 per admission</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
<td>$0 per admission</td>
</tr>
<tr>
<td>Maximum of 120 days per calendar year</td>
<td></td>
</tr>
<tr>
<td><strong>Hospice Care</strong></td>
<td>$0 per admission</td>
</tr>
<tr>
<td><strong>Second Surgical Opinion Provided By a Non-Participating Provider</strong></td>
<td>40% of the Reasonable Charges</td>
</tr>
<tr>
<td>Maximum of Three Such Opinions Per Member per calendar year</td>
<td></td>
</tr>
</tbody>
</table>

### ADDITIONAL BENEFITS

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Examination by a Specialist (including refraction) as per schedule in the Certificate</td>
<td>$15 per visit</td>
</tr>
<tr>
<td><strong>Subluxation</strong></td>
<td>$15 per visit</td>
</tr>
<tr>
<td>20 visits per calendar year</td>
<td></td>
</tr>
<tr>
<td><strong>Durable Medical Equipment (DME)</strong></td>
<td>$0 per item</td>
</tr>
<tr>
<td>Counts toward the Member’s medical Maximum Out-of-Pocket Limit</td>
<td></td>
</tr>
<tr>
<td><strong>DME Maximum Benefit</strong></td>
<td>Unlimited per Member, per calendar year</td>
</tr>
</tbody>
</table>
**Subscriber Eligibility:** All active full-time employees of the **Contract Holder** who regularly work at least the minimum number of hours per week as defined by the **Contract Holder** and agreed to by **HMO**.

Eligible for benefits on the date of hire.

**Dependent Eligibility:** A dependent unmarried child of the **Subscriber** as described in the Eligibility and Enrollment section of the **Certificate** who is:

i. under 25 years of age; or

ii. under 25 years of age, dependent on a parent or guardian **Member**, and attending a recognized college or university, trade or secondary school on a full-time basis; or

iii. chiefly dependent upon the **Subscriber** for support and maintenance, and is 19 years of age or older but incapable of self-support due to mental or physical incapacity, either of which commenced prior to: 25, or if a student, 25.

**Termination of Coverage:** Coverage of the **Subscriber** and the **Subscriber’s** dependents who are **Members**, if any, will terminate on the earlier of the date the **Group Agreement** terminates or on the next **Premium** due date following the date on which the **Subscriber** ceased to meet the eligibility requirements.

Coverage of **Covered Dependents** will cease on the next **Premium** due date following the date on which the dependent ceased to meet the eligibility requirements.