AETNA LIFE INSURANCE COMPANY

GROUP APPLICATION

Entire Agreement: This Group Application, including the Evidence of Coverage, Summary of Benefits, any Supplemental Benefits, and any Exhibits, Amendments, endorsements, inserts or attachments, herein defined as ("Agreement") constitutes the entire Agreement between the City of Houston ("Group") and Aetna Life Insurance Company, a company licensed as a health insurer ("AETNA"), and on the Effective Date of Coverage, supersedes all other prior and contemporaneous arrangements, understandings, agreements, negotiations, and discussions between the parties, whether written or oral, previously issued by AETNA for Covered Services provided under this Agreement. Exhibit I, Additional Terms and Conditions, Exhibit II Premium Rates, Exhibit IIA Rate Renewal Calculation Formula, Exhibit III Evidence of Coverage and Summary of Benefits, and Exhibit IV Aetna Life Insurance Company Formulary and Excluded Drug Listing are attached hereto and are incorporated in their entirety herein.

Governmental Approval: Certain provisions of this Agreement must be filed with the Centers for Medicare and Medicaid Services ("CMS") after its approval by the Group and prior to the distribution of any of the terms hereof, including the provisions contained in the Evidence of Coverage and Summary of Benefits and all documents incorporated therein, to persons eligible for Coverage under the Plan. AETNA may be required to revise such terms and provisions to obtain CMS's approval or to comply with Federal law and regulation, and Group agrees to such changes subject to the prior written approval of Group's Human Resources Director.

Group: City of Houston

Benefit Level: Plan: Aetna Medicare Open Plan (Medicare Advantage (MA) Private Fee For Service Plan) (hereinafter referred to as the "PFFS Plan") -- Group Specific Evidence of Coverage and Summary of Benefits

Group Agreement Effective Date: January 1, 2007

Term of Group Agreement: The initial term shall be: From January 1, 2007 to December 31, 2007. Thereafter, renewals shall be in accordance with the terms and conditions of Exhibit II.

Premium Rates: For Premium Rates see Exhibit II attached hereto and incorporated in its entirety herein.

Premium Due Dates: The Group Agreement Effective Date and the 1st day of each succeeding calendar month. Premium due date shall be subject to a thirty (30) day grace period.

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Notices : Written notice shall be given by certified U.S. Mail, return receipt requested, postage prepaid, to AETNA at:

AETNA LIFE INSURANCE COMPANY

One Prudential Circle
Sugarland, Texas 77478
(281)-637-5500

And to Group at:

CITY OF HOUSTON

Human Resources Director
611 Walker, Suite 4A
Houston, Texas 77002

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IN WITNESS WHEREOF, and as duly authorized, the parties hereto execute this Agreement in duplicate with the Effective Date herein provided.

ATTEST/SEAL:

By: Janice Pinto
Name: Janice Pinto
Title: Executive Assistant

AETNA LIFE INSURANCE COMPANY

By:
Name: Scott Stauffer
Title: Vice President National Accounts Sales Support

ATTEST/SEAL:

By:
City Secretary

CITY OF HOUSTON, TEXAS

By: Bill White
Mayor

APPROVED:

By:
Group's Human Resources Director

COUNTERSIGNED

By:
City Controller

APPROVED AS TO FORM:

By: Tom K. Hargrove
Sr. Assistant City Attorney
L.D. File No.

DATE COUNTERSIGNED

11-22-06

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EXHIBIT I TO GROUP APPLICATION

Additional Terms and Conditions

A. Compliance With Equal Employment Opportunity Ordinance. AETNA shall comply with all provisions of the City's Equal Employment Opportunity Ordinance as set out in Exhibit A.

B. Minority and Women Business Enterprises. AETNA agrees to use good faith efforts to carry out the policy of the Group with regard to minority and women business enterprises as set out in Exhibit B.

C. Allocation and Appropriation of Funds by the Group. AETNA agrees to the terms and conditions set out in Exhibit C regarding the Group's allocation and appropriation of funds to pay AETNA under this Agreement.

D. Service Performance Standards. AETNA agrees to meet the service performance criteria set out in Exhibit D, provided that the sole remedy for any breach of those standards shall be the penalties contained therein.

E. Management Reports. AETNA will provide the management reports that are listed in Exhibit E to the Group at such times as are mutually agreed upon between the Group and AETNA.

F. Supplemental Terms & Conditions. AETNA and Group agree to be bound by all applicable supplemental terms and conditions set forth in Exhibit F.

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EXHIBIT "A"

EQUAL EMPLOYMENT OPPORTUNITY

1. The contractor*, subcontractor, vendor, supplier, or lessee will not discriminate against any employee or applicant for employment because of race, religion, color, sex, national origin, or age. The contractor, subcontractor, vendor, supplier, or lessee will take affirmative action to ensure that applicants are employed and that employees are treated during employment without regard to their race, religion, color, sex, national origin, or age. Such action will include, but not be limited to, the following: employment; upgrading; demotion or transfer; recruitment advertising; layoff or termination; rates of pay or other forms of compensation and selection for training, including apprenticeship. The contractor, subcontractor, vendor, supplier or lessee agrees to post in conspicuous places available to employees, and applicants for employment, notices to be provided by the City setting forth the provisions of this Equal Employment Opportunity Clause.

2. The contractor, subcontractor, vendor, supplier, or lessee states that all qualified applicants will receive consideration for employment without regard to race, religion, color, sex, national origin or age.

3. The contractor, subcontractor, vendor, supplier, or lessee will send to each labor union or representatives of workers with which it has a collective bargaining agreement or other contract or understanding, a notice to be provided by the agency contracting officer advising the said labor union or worker's representative of the contractor's and subcontractor's commitments under Section 202 of Executive Order No. 11246, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

4. The contractor, subcontractor, vendor, supplier, or lessee will comply with all provisions of Executive Order No. 11246 and the rules, regulations, and relevant orders of the Secretary of Labor or other Federal Agency responsible for enforcement of the equal employment opportunity and affirmative action provisions applicable and will likewise furnish all information and reports required by the Mayor and/or Contractor Compliance Officer(s) for purposes of investigation to ascertain and effect compliance with this program.

5. The contractor, subcontractor, vendor, supplier, or lessee will furnish all information and reports required by Executive Order No. 11246, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to all books, records, and accounts by the appropriate City and Federal Officials for purposes of investigations to ascertain compliance with such rules, regulations, and orders. Compliance reports filed at such times as directed shall contain information as to the employment practice policies, program, and work force statistics of the contractor, subcontractor, vendor, supplier, or lessee.

6. In the event of the contractor's, subcontractor's, vendor's, supplier's, or lessee's noncompliance with the non-discrimination clause of this contract or with any of such rules, regulations, or orders, this contract may be canceled, terminated, or suspended in whole or in part, and the contractor, subcontractor, vendor, supplier, or lessee may be declared ineligible for further City contracts in accordance with procedures provided in Executive Order No. 11246, and such other sanctions may be imposed and remedies invoked as provided in the said Executive Order, or by rule, regulation, or order of the Secretary of Labor, or as may otherwise be provided by law.

7. The contractor shall include the provisions of paragraphs 1-8 of this Equal Employment Opportunity Clause in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Section 204 of Executive Order No. 11246 of September 24, 1965, so that such provisions will be binding upon each subcontractor or vendor. The contractor will take such action with respect to any subcontractor or purchase order as the contracting agency may direct as a means of enforcing such provisions including sanctions for noncompliance; provided, however, that in the event the contractor becomes involved in, or is threatened with litigation with a subcontractor or vendor as a result of such direction by the contracting agency, the contractor may request the United States to enter into such litigation to protect the interests of the United States.

8. The contractor shall file and shall cause his or her subcontractors, if any, to file compliance reports with the City in the form and to the extent as may be prescribed by the Mayor. Compliance reports filed at such times as directed shall contain information as to the practices, policies, programs, and employment policies and employment statistics of the contractor and each subcontractor.

* For purposes of this Exhibit "A", Contractor shall be used instead of AETNA.

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EXHIBIT "B"

Minority and Women Business Enterprises – AETNA

It is the City's policy to ensure that Minority and Women Business Enterprises ("MWBEs") have the full opportunity to compete for and participate in City contracts. The objectives of Chapter 15, Article V of the City of Houston Code of Ordinances, relating to City-wide Percentage Goals for contracting with MWBEs, are incorporated into this Agreement.

AETNA shall make good faith efforts to award subcontracts or supply agreements in at least an amount equal to two percent (2%) of the costs incurred under the Agreement (which costs can include IPAs, pharmacies, DME providers, home health facilities, clinics, and other related firms), excluding taxes, Hospital charges and outpatient surgery facility charges. The City's policy does not require AETNA to in fact meet or exceed this goal, but it does require AETNA to objectively demonstrate that it has made good faith efforts to do so. To this end, AETNA shall maintain records showing

(1) subcontracts and supply agreements with Minority Business Enterprises,
(2) subcontracts and supply agreements with Women's Business Enterprises, and
(3) specific efforts to identify and award subcontracts and supply agreements to MWBE.

AETNA shall submit periodic reports of its efforts under this Section to the Affirmative Action Director in the form and at the times he or she prescribes. In these reports, AETNA will identify all local Texas MWBE subcontractors that meet the City's MWBE qualifications. AETNA shall require written subcontracts with all such MWBE subcontractors and suppliers and shall submit all disputes with all such MWBE subcontractors to binding arbitration if directed to do so by the Affirmative Action Director. All agreements must contain the terms set out in Exhibit "B-1." It is understood and agreed that AETNA may have business relationships with a variety of other vendors that qualify under general MWBE standards in other parts of the country, which would not be required to be subject to the requirements of Exhibit "B-1".

In addition to the above MWBE goal, the City has a strong commitment to offering its employees a diverse Provider network. The City will monitor the Provider network to ensure that it represents a cross section of the community and that at least thirty percent (30%) of the physicians are minority and/or female.

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EXHIBIT "B-1"

MWBE SUBCONTRACT TERMS

AETNA shall ensure that all subcontracts with local Texas MWBE subcontractors and suppliers meeting the City's MWBE requirements are clearly labeled "**THIS AGREEMENT IS SUBJECT TO BINDING ARBITRATION ACCORDING TO THE TEXAS GENERAL ARBITRATION ACT**" and contain the following terms:

1. (MWBE subcontractor) shall not delegate or subcontract more than 50% of the work under this subcontract to any other subcontractor or supplier without the express written consent of the City of Houston's Affirmative Action Director ("the Director").

2. (MWBE subcontractor) shall permit representatives of the City of Houston, at all reasonable times, to perform (1) audits of subcontractor's books and records, and (2) inspections of all places where work is to be undertaken in connection with this subcontract. Subcontractor shall keep its books and records available for inspection for at least 4 years after the end of its performance under this subcontract. Nothing in this provision shall change the time for bringing a cause of action.

3. Within 5 business days of execution of this subcontract, AETNA (prime contractor) and Subcontractor shall designate in writing to the Director an agent for receiving any notice required or permitted to be given under Chapter 15 of the Houston City Code of Ordinances, along with the street and mailing address and phone number of the agent.

4. Any controversy between the parties involving the construction or application of any of the terms, covenants, or conditions of this subcontract must, upon the written request of one party served upon the other or upon notice by the Director served on both parties, be submitted to binding arbitration, under the Texas General Arbitration Act (Tex. Civ. Prac. & Rem. Code Ann., Ch. 171 -- "the Act"). Arbitration must be conducted according to the following procedures:

- a. Upon the decision of the Director or upon written notice to the Director from either party that a dispute has arisen, the Director shall notify all parties that they must resolve the dispute within 30 days or the matter may be referred to arbitration.
- b. If the dispute is not resolved within the time specified, any party or the Director may submit the matter to arbitration conducted by the American Arbitration Association under the rules of the American Arbitration Association, except as otherwise required by the City's contract with the American Arbitration Association on file in the City's Affirmative Action Division Office.
- c. Each party shall pay all fees required by the American Arbitration Association and sign a form releasing the American Arbitration Association and its arbitrators from liability for decisions reached in the arbitration.
- d. If the American Arbitration Association no longer administers Affirmative Action arbitration for the City, the Director shall prescribe alternate procedures to provide arbitration by neutrals in accordance with the requirements of Chapter 15 of the Houston City Code of Ordinances.

EXHIBIT "C"

Limit of Appropriation

- (1) The City's duty to pay money to AETNA under this Agreement is limited in its entirety by the provisions of this Section.

- (2) In order to comply with Article II, Sections 19 and 19a of the City's Charter and Article XI, Section 5 of the Texas Constitution, the City has appropriated and allocated the sum of $212,000 to pay money due under this Agreement (the "Original Allocation"). The executive and legislative officers of the City, in their discretion, may allocate supplemental funds for this Agreement, but they are not obligated to do so. Therefore, the parties have agreed to the following procedures and remedies:

- (3) The City Council hereby approves a supplemental allocation by sending a notice signed by the Group's Human Resources Director and the Controller in substantially the following form:

"NOTICE OF SUPPLEMENTAL ALLOCATION OF FUNDS"

TO:	Aetna Life Insurance Company
FROM:	City of Houston, Texas (the "City")
DATE:	[Date of notice]
SUBJECT:	Supplemental allocation of funds for the purpose of the "[title of this Agreement]" between the City and Aetna Life Insurance Company countersigned by the City Controller on (Date of Countersignature) (the "Agreement").

I, (name of City Controller), City Controller of the City of Houston, certify that the supplemental sum of $_____, upon the request of the below-signed Director, has been allocated for the purposes of the Agreement out of funds appropriated for this purpose by the City Council of the City of Houston. This supplemental allocation has been charged to such appropriation.

The aggregate of all sums allocated for the purpose of such Contract, including the Original Allocation, and all supplemental allocations (including this one), as of the date of this notice, is $_____.

SIGNED:

(Signature of the City Controller)
City Controller of the City REQUESTED:

(Signature of the Director)Director

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(4) The Original Allocation plus all supplemental allocations are the Allocated Funds. The City shall never be obligated to pay any money under this Agreement in excess of the Allocated Funds. AETNA must assure itself that sufficient allocations have been made to pay for services it provides. If Allocated Funds are exhausted, AETNA's only remedy is suspension or termination of its performance under this Agreement, and it has no other remedy in law or in equity against the City and no right to damages of any kind.

EXHIBIT D

SERVICE PERFORMANCE STANDARDS

The Service Performance Standards described herein shall apply to the Agreement between AETNA and Group to which this Exhibit D is attached. The Service Performance Standards set out in this Exhibit D are limited solely to the medical benefit Coverage under AETNA and do not include the following: prescription drug; hearing; vision; alternative health services; silver sneakers; or other supplemental services, if applicable, under the medical management programs provided by AETNA when elected by the Group.

ADDENDUM D-1

SERVICE	LEVEL OF PERFORMANCE	PREMIUM AT RISK
Member Satisfaction		
1. Member satisfaction: Aetna guarantees a positive response rate for the City of Houston PFFS members of 70.0% or better on the standard Aetna Performance Tracking Process for the Medicare Advantage products. The survey is based on a randomly selected sample of actively enrolled members. Interviews are conducted on a continuous basis throughout the year.	Positive response rate of 70% or higher.	0.02% of the guarantee period premiums for each 1.0% if it fails to meet a positive response rate of 70.0% or better up to a maximum reduction of **0.1%** of the guarantee period premiums.
Customer Service		
2. Average Speed of Answer: Aetna guarantees that the average speed of answer for the units providing City of Houston member services will not exceed 30 seconds.	Average speed of answer will not exceed 30 seconds.	0.04% of the guarantee period premiums for each full second that the average speed of answer exceeds 30 seconds up to a maximum reduction of **0.2%** of the guarantee period premiums.
3. Abandoned Calls: Aetna guarantees that the average rate of telephone abandonment for the units providing City of Houston member services will not exceed 5.0%.	Will not exceed 5.0%.	0.02% of the guarantee period premiums for each 1.0% that the average abandonment rate exceeds 5.0% up to a maximum reduction of **0.1%** of the guarantee period premiums.

Medical Management		
4. Reduction in Inpatient Bed Days: Aetna guarantees that the Medicare Advantage national average Inpatient Bed Days per thousand members will be at least 20% lower than the national average Inpatient Bed Days per thousand members in Traditional Fee for Service Medicare.	Inpatient Bed Days per thousand members will be at least 20.0% lower than the national average Inpatient Bed Days per thousand members.	0.02% of the guarantee period premiums for each 1.0% that the reduction to average bed days per thousand members is less than 20.0% when compared with Traditional Medicare up to a maximum reduction of **0.1%** of the guarantee period premiums.
ID Cards		
5. ID Card Issuance: Aetna guarantees that it will produce and mail ID cards to plan participants within 10 business days of receiving confirmation of eligibility from the Centers for Medicare & Medicaid Services (CMS).	ID cards mailed within 10 business days of receiving confirmation of eligibility (CMS).	**0.1%** of the guarantee period premiums if Aetna fails to produce and mail ID cards to City of Houston members within 10 business days of receiving the eligibility confirmation file from CMS.
Claims Processing		
6. Financial Accuracy: Aetna guarantees that the guarantee period dollar accuracy of the claim payment dollars will be 99.0% or higher.	Accuracy of the claim payment dollars will be 99.0% or higher.	0.02% of the guarantee period premiums for each 1.0% that financial accuracy drops below 99.0% up to a maximum reduction of **0.1%** of the guarantee period premiums.
7. Turnaround Time: Aetna guarantees that the claim turnaround time during the guarantee period will not exceed 6 *business* days for 90.0% of the processed claims on a cumulative basis each year.	Turnaround time will not exceed 6 *business* days for 90.0% of the processed claims on a cumulative basis each year.	Aetna will reduce its compensation by an amount equal to 0.02% of the guarantee period premiums for each full day that Turnaround Time exceeds 6 business days for 90.0% of all claims up to a maximum reduction of **0.1%** of the guarantee period premiums.

Account Management		
8. Overall Account Management: Aetna guarantees that the services (i.e., on-going financial, eligibility, drafting and benefits administration and continued customer support) provided by the Field Office Account Management Staff during the guarantee period will be satisfactory to the City of Houston.	Account Management will be Satisfactory.	If the score on the first report card is below an average rating of 3.0 and the service improves to an average of 3.0 for the second and subsequent surveys, no credit is due. Should the score from the first report card and the average of the remaining report cards fall below a 3.0 (meaning that service levels have not improved), Aetna will make a mutually agreed upon reduction in compensation, subject to a maximum reduction of **0.2%** of the guarantee period premiums.
Total Premium at Risk For Performance Standards		**1.0%**

General Performance Guarantee Provisions – Fully Insured Premium

Aetna provides health benefits administration and other services for the fully-insured Medicare Advantage medical plans. The services set forth in this document will be provided by Aetna.

Guarantee Period

The guarantees described herein will be effective for a period of 12 months and will run from **January 1, 2007 through December 31, 2007** (hereinafter "guarantee period"), and for each renewal period.

The performance guarantees shown above will apply to the fully-insured Medicare Advantage medical plans administered under the Group Agreement. These guarantees **do not** apply to non-Aetna benefits or networks.

If Aetna processes runoff claims upon termination of the Group Agreement, performance guarantees of Turnaround Time, Financial Accuracy and Total Claim Accuracy will not apply to claims processed after termination date. Further, performance guarantees described herein will not apply to the guarantee period claims if termination is prior to the end of the guarantee period.

For any performance guarantee that is unsatisfactory we will develop an improvement plan to achieve the stated performance guarantees.

Aggregate Maximum at Risk

In total, Aetna agrees to place **1.0%** of its applicable guarantee period premiums at risk through the Performance Guarantees outlined in this document. The guarantee period premiums will be calculated at the end of the guarantee period and will be based on the amount of premium paid by the Group to Aetna for Medicare Advantage Medical plans throughout the guarantee period.

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Change in Circumstances

In the event of a material change in the plan initiated by Group or by legislative action that impacts the claim adjudication process, member service functions or network management, Aetna and Group will negotiate appropriate changes to the guarantees set forth in this Exhibit D to reflect such changed circumstances. Group Human Resources Director is authorized to negotiate and approve such changes.

Refund Process

At the end of each guarantee period, Aetna will compile its Performance Guarantees results and report to Group by March 1st of the following year. If necessary, Aetna will provide a "lump sum" refund for any penalties incurred by Aetna by April 1st following the contract year.

Measurement Criteria

Aetna's internal quality results for the units processing City of Houston's claims will be used to determine guarantee compliance for the Turnaround Time and Total Claim Accuracy Guarantees.

1. Member Satisfaction

Definition: Aetna guarantees a positive response rate of 70.0% or better for City of Houston PFFS members on the standard Aetna Performance Tracking Process for the Medicare Advantage products. Using random sampling, Aetna conducts telephone surveys across Aetna's Medicare Advantage membership, using DSS Research, an external market research vendor. These surveys are conducted continuously from the first quarter through the fourth quarter and in all total 200 surveys per quarter and 800 surveys annually. Satisfaction on these surveys is measured using a 5 point scale and Aetna reports and details results at both the product and region level.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.02% of the guarantee period premiums for each 1.0% if it fails to meet a positive response rate of 70.0% or better. Results of the Aetna Performance Tracking Process will be used as the measurement criteria. These surveys are performed based on statistically valid samples of members, by product across all customers. There will be a maximum reduction of 0.1% of the guarantee period premiums.

Customer Service

2. Average Speed of Answer

Guarantee: Aetna guarantees that the average speed of answer for the units providing City of Houston member services will not exceed 30 seconds.

Definition: On an ongoing basis, Aetna measures telephone response time through monitoring equipment that produces a report on the average speed of answer. Average speed of answer is defined as the amount of time that elapses between the time a call is received into the telephone system and the time a representative responds to the call. The result expresses the sum of all waiting times for all calls answered by the queue divided by the number of incoming calls answered. ASA measures the average speed of answer for all callers answered. Interactive Voice Response (IVR) system calls are not included in the measurement of ASA.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.04% of the guarantee period premiums for each full second that the average speed of answer exceeds 30 seconds. There will be a maximum reduction of **0.2%** of the guarantee period premiums. Aetna's results for the units providing member services for City of Houston will be used.

3. Abandoned Calls

Guarantee: Aetna guarantees that the average rate of telephone abandonment for the units providing City of Houston member services will not exceed 5.0%.

Definition: On an ongoing basis, Aetna measures telephone response time through monitoring equipment that produces a report on the average abandonment rate. The abandonment rate measures the total number of calls abandoned divided by the number of calls accepted into the unit.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.02% of the guarantee period premiums for each 1.0% that the average abandonment rate exceeds 5.0%. There will be a maximum reduction of **0.1%** of the guarantee period premiums. Aetna's results for the units providing member services for City of Houston will be used.

Medical Management

4. Reduction in Inpatient Bed Days

Guarantee: Aetna guarantees that the Medicare Advantage national average Inpatient Bed Days per thousand members will be at least 20.0% lower than the national average Inpatient Bed Days per thousand members in Traditional Fee for Service Medicare.

Definition: Number of inpatient hospital days per 1,000 members on an annual basis. Aetna's Medicare Advantage book of business results for states in which Aetna has a minimum of 20,000 members for a minimum of 12 months will be used to measure the reduction in bed days compared to Traditional Fee for Service Medicare in the same states.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.02% of the guarantee period premiums for each 1.0% that the reduction to average bed days per thousand members is less than 20.0% when compared with Traditional Fee for Service Medicare. There will be a maximum reduction of **0.1%** of the guarantee period premiums. Aetna's results for the units providing medical management for City of Houston will be used.

ID Card Issuance

5. ID Card Production and Distribution

Guarantee: Aetna guarantees that it will produce and mail ID cards to plan participants within 10 business days of receiving confirmation of eligibility from the Centers for Medicare & Medicaid Services (CMS).

Definition: For all ***complete, accurate and viable*** open enrollment eligibility data provided by City of Houston, accepted by the system, and confirmed by CMS, Aetna agrees to produce and mail ID cards within 10 business days of file receipt from CMS.

Penalty and Measurement Criteria: Aetna will reduce its compensation by **0.1%** of the guarantee period premiums if Aetna fails to produce and mail ID cards to City of Houston members within 10 business days of receiving confirmation of eligibility from CMS. Aetna's implementation team records will be used to determine whether ID cards were produced and mailed within the specified time frame.

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Claims Processing

6. Financial Accuracy

Guarantee: Aetna guarantees that the guarantee period dollar accuracy of the claim payment dollars will be 99.0% or higher.

Definition: Financial accuracy is measured by the dollar amount of claims paid accurately divided by the total dollars paid. Aetna considers each underpayment and overpayment an error; Aetna does not offset one by the other.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.02% of the guarantee period premiums for each 1.0% that financial accuracy drops below 99.0%. There will be a maximum reduction of **0.1%** of the guarantee period premiums.

Aetna's audit results for the unit processing City of Houston's claims will be used. The results will be based on Aetna's applicable Quality Assessment Policy in effect at the time of the audit.

7. Turnaround Time

Guarantee: Aetna guarantees that the claim turnaround time during the guarantee period will not exceed 6 *business* days for 90.0% of the processed claims on a cumulative basis each year.

Definition: Aetna measures turnaround time from the claimant's viewpoint; that is, from the date the claim is received in the service center to the date that it is processed (paid, denied or pended).

Penalty and Measurement Criteria: If the cumulative year turnaround time (TAT) exceeds the day guarantee as stated above, Aetna will reduce its compensation by an amount equal to 0.02% of the guarantee period premiums for each full day that Turnaround Time exceeds 6 business days for 90.0% of all claims. There will be a maximum reduction of **0.1%** of the guarantee period premiums.

Account Management

8. Overall Account Management Guarantee

Guarantee: Aetna guarantees that the services (i.e., on-going financial, eligibility, drafting, and benefit administration and continued customer support) provided by the Field Office Account Management Staff during the guarantee period will be satisfactory to City of Houston.

Measurement Criteria: Via quarterly responses to the Account Management Evaluation Tool, sent the first month of the quarter, City of Houston agrees to make Aetna aware of possible sources of dissatisfaction throughout the guarantee period. City of Houston responses to the evaluation tool will evaluate account management services in the following categories: technical knowledge, accessibility of personnel, responsiveness of personnel, interpersonal skills, communication skills (written and oral) and overall assessment of the services provided to City of Houston. Each category will be given a rating of 1 - 5 with 1 = lowest, 5 = highest. Aetna will tally the results from the report cards when received. The results of the first survey will be used to facilitate a discussion between City of Houston and the Sales Vice President in our field office, regarding the results achieved and opportunities for improvement.

If the report cards are not completed and returned within one month of receipt, it will be assumed that the service provided to City of Houston is satisfactory. If the score on the first report card is below an average rating of 3.0 and the service improves to an average of 3.0 for the second and subsequent surveys, no credit is due. Satisfactory service would equal a score of 3.0 and would be based on the total average of 23 questions with a rating scale of 1 to 5. Should the score from the first report card and the average of the remaining report cards fall below a 3.0 (meaning that service levels have not improved), Aetna will make a mutually agreed upon reduction in compensation, subject to a maximum reduction of **0.2%** of the guarantee period premiums.

EXHIBIT E

AETNA MANAGEMENT REPORTS

AETNA shall provide the following reports to Group. Such reports will provide data necessary for Group to analyze their medical costs (professional and institutional), prescription costs, catastrophic costs, disease management effectiveness as well as cost analysis by provider specialty. In addition, AETNA can devise and develop various Management reports as requested by the Group.

Monthly:

- Per Member Per Month Professional Costs by Provider Specialty Report
- Per Member Per Month Institutional Costs by Institutional Service Category Report
- Catastrophic Claim Report (de-identified Member listing)
- Membership Totals by Primary Care Physician
- Bed Day Utilization Report (1 month retrospective)
- Total Claims (professional, institutional and prescription drug) Dollars Paid (1 month retrospective)
- Encounter Data (de-identified)
- Enrollment Reconciliation Report
- Disenrollment Report

Quarterly:

- Institutional Costs by Discharge DRG
- Inpatient Utilization by Hospital
- Prescription Drug Summary (sorted by drug)
- Out of Network Costs Report
- Disease Management Enrollment and Costs by Program and Disease Category
- ER Utilization Report

Other reports may be available at no charge and can be provided in addition to the reports listed above. Reports shall be provided in a reporting format as agreed between the parties.

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EXHIBIT F

SUPPLEMENTAL TERMS & CONDITIONS

I. DEFINITIONS

Except as expressly otherwise provided in the Agreement or unless the context otherwise requires, the following words and phrases used in this Agreement shall have the following meanings:

"AETNA" means AETNA LIFE INSURANCE COMPANY, organized as a life and health insurance company and licensed by the Texas Department of Insurance.

Basic Plan Benefits" means those benefits set forth in the Evidence of Coverage for the Aetna PFFS Plan.

"Calendar Year" means the period beginning January 1 of any year and ending December 31 of the same year.

"Contract Year" With the exception of the initial Contract Year, which runs from January 1, 2007 through December 31, 2007, this shall mean the period of twelve (12) months commencing on the effective date of any subsequent renewal and each twelve (12) month period thereafter, unless otherwise terminated as hereinafter provided.

"EOC" means the Evidence of Coverage for the Aetna PFFS Plan, which is a document outlining coverage for Members that is issued pursuant to this Agreement.

"Group" means the City of Houston.

"Member Effective Date" means the first date on which an individual Member is entitled to receive benefits under the Plan.

"Termination Date" means (a) for a Member, the last date on which the Member is eligible for Coverage, or (b) for the Group, the last date on which this Agreement is in force.

II. TERMINATION

A. Termination of Members

1. No Coverage will be provided to any Member if the Group fails to pay the Premium for the first month of this Agreement. This Agreement may be terminated for non-payment of Premium if the Group fails to pay Premiums for the second or subsequent months by the end of the thirty (30) day grace period. If so terminated, a Member's Termination Date shall be the day following the expiration of the grace period and the Member shall be liable for the cost of services received during the grace period.

2. For any Member who ceases to be eligible under the EOC or this Agreement the Termination Date shall be the date such eligibility ceases.

3. If the Member is an inpatient on the Termination Date of this Agreement, benefits will terminate for such Member at 12:01 a.m. on the day next following the Termination Date. However, in the event that Group replaces the Plan with another group health care plan or program of any kind, AETNA shall cooperate with such other plan or program in the orderly transition of covered care for Members who are then inpatients.

4. For a Dependent who qualifies as a Survivor, the Termination Date shall be the earliest of the following dates:

a. the last day of the Plan month in which such Dependent marries or remarries (but this event shall only terminate coverage of the Dependent who is marrying or remarrying, and not the coverage of the other Dependents);

b. as to any Dependent child of the deceased Subscriber, the last day of the Plan month in which such Dependent child ceases to be a Dependent as defined by the Plan;

c. the last day of the Plan month in which the Dependent becomes eligible for coverage hereunder as an Eligible Employee, or becomes eligible for coverage under Medicare or any other employer-sponsored policy, plan or program of group health coverage; or

d. The date of termination of the Plan.

B. Termination of Member Coverage

A Member's Coverage will terminate immediately for any of the following reasons:

1. this Agreement terminates;
2. Member voluntarily disenrolls from the Plan.
3. the Member no longer lives in the Service Area, or if the Member resides temporarily outside the Service Area for more than six (6) consecutive months;
4. the Member becomes covered under an alternative Medicare Advantage Plan;
5. AETNA's contract with CMS terminates;
6. Member's death; or
7. Non-payment of Premium.

C. Termination of this Agreement

1. The Group may terminate this Agreement for cause:

a. sixty (60) days after delivery of written notice by Group to AETNA, upon material failure of AETNA to comply with this Agreement, unless such failure described in the notice is cured within said sixty (60) days.

b. upon 30 days written notice to the AETNA, if AETNA makes a material change to any provision required by law to be disclosed to Group or Members.

2. AETNA may terminate the Group upon ninety (90) days written notice, unless such failure described in the notice is cured within said ninety (90) days, in the case of:

   a. The Group has committed fraud or intentional misrepresentation of a material fact to AETNA; or

   b. No Members live in the Service Area; or

   c. Noncompliance by the Group with, or changes in, material provisions of the Plan relating to the Group's contribution toward Premium and eligibility requirements for membership in the Group, which requirements are, in accordance with State law, applicable to the offering of a group health plan in the large group market.

3. AETNA may terminate the Group upon thirty (30) days' written notice in the case of non-payment of Premium through the end of the thirty (30) day grace period or other material breach of this Agreement that is uncured at the end of the grace period, and if so terminated, all Coverage will be canceled as of the day following the expiration of the grace period; provided that Members shall be financially responsible for reimbursement of the claims of Providers for Covered Services provided to Members during and subsequent to the grace period.

4. AETNA may terminate the Group upon one hundred and eighty (180) days' written notice if AETNA ceases to offer Coverage in the Service Area in accordance with state or federal law.

5. Except as specified above, AETNA shall not have the right to terminate this Agreement.

6. Aetna agrees to notify Members of termination of this Agreement for any reason, including non-payment of Premium. Aetna also agrees to notify Members of the involuntary termination of their coverage under this Agreement for any reason.

D. Notification of Members' Ineligibility
Group shall notify AETNA within thirty (30) days after a Member ceases to be eligible for benefits under this Agreement. Failure to do so will make the Group liable for any expenses incurred by the Plan, whether or not paid, due to the Group's failure to notify.

E. Refunds/Credits
If the Coverage of a Member is terminated, Premium payments received on account of the terminated Member applicable to periods after the Effective Date of termination shall be refunded or credited to Group, at AETNA's sole option, within thirty (30) days, and neither AETNA nor the Group shall have any further liability under this Agreement with respect to such Member. The maximum refund or credit allowable is equal to two (2) months of Premium applicable to such terminated Member, which shall include the month during which AETNA is notified in writing of such termination and the next previous month, if applicable. Any claim for refund or credit by Group must be made within sixty (60) days from the Effective Date of termination of the Member's Coverage or otherwise such claims shall be deemed waived.

F. Health Status Termination.
Coverage will not be terminated on the basis of a Member's health status or health care needs, nor because a Member has exercised the Member's rights under the Appeals and Grievance process as set forth in the Evidence of Coverage.

III. PAYMENT REQUIREMENTS

1. The required payments for the services and benefits made available hereunder are set forth in the Group Application and shall be due and payable in advance on or before the first day of the month for which each such payment is made or is to be made. No proration of the payments will be made under this Agreement and change in Members' status shall be effective only on the first day of each month.

2. Interest on late Premiums from the date such Premiums were due will be charged at a rate not to exceed the maximum allowable by law. Unpaid interest will be due and payable upon notice thereof to Group from AETNA. However, no interest shall accrue until thirty (30) days after the Group is invoiced for the late Premium.

IV. IDENTIFICATION CARDS

1. AETNA shall issue identification cards for the Members.

2. Possession of an AETNA identification card in and of itself confers no rights to services or other benefits. The holder of the card and the name on the card must be the same and the holder of the card must be, in fact, a Member on whose behalf all applicable charges under this Agreement have actually been paid. Any person receiving services or other benefits to which he or she is not entitled pursuant to this Agreement, through use of an AETNA identification card or otherwise, shall be chargeable therefore at the actual cost of services rendered. If any Member permits the use of his or her AETNA identification card by any other person, such card may be recalled and invalidated by AETNA, and all rights of such Member pursuant to this Agreement may be terminated in accordance with Section II of this Agreement.

V. AMENDMENT OF AGREEMENT

1. This Agreement may be amended at any time, without the consent of the Members, or any other person having beneficial interest in it, upon written request made by the Group and agreed to by AETNA. Any such Amendment shall be without prejudice to any claim arising prior to the date of such Amendment.

2. AETNA may alter or revise the terms of this Agreement and/or any Evidence of Coverage including the Summary of Benefits and Premiums, if necessary in order to comply with state, federal or local law. Specifically, upon mutual agreement, AETNA and Group, by and through Group's Human Resources Director or such other person with similar authority, may alter or revise the terms of this Agreement and/or any Evidence of Coverage including the Summary of Benefits and Premiums as a result of changes implemented by Group or AETNA as a result of the implementation of Medicare Part D. In the event of such alteration or revision, including any increase in Premium due to additional benefit enhancements, mandated benefits or expanded eligibility criteria, or other changes in laws specifically applicable to health maintenance organizations that raise AETNA's cost of providing benefits under the Plan, AETNA shall give the Group at least sixty (60) days prior written notice, which notice shall be considered to have been given when mailed to the Group at the address shown on the records of AETNA. The alteration or revision shall become effective on the date contained in the notice, unless the Group provides written notice within fifteen (15) days after giving of notice by AETNA of its intention to terminate this Agreement. Any increase in Premium must be limited to actual demonstrated cost increases and shall be approved by the Group's Human Resources Director or such other person with similar authority.

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3. Furthermore, the parties acknowledge and agree that AETNA may alter, amend, or otherwise modify the Member's Evidence of Coverage to increase benefits, decrease Copayments, Coinsurance, or otherwise provide Members with additional services or benefits (collectively "Enhanced Benefits") by providing Group's Human Resources Director with not less than sixty (60) days prior written notice; provided, however, that Group shall not be obligated to pay AETNA additional Premiums related directly to such Enhanced Benefits.

VI. COVERAGE AND ACCESS TO PROVIDERS

1. **Covered Benefits.** AETNA will provide coverage for Basic Plan Benefits to Members subject to the terms and conditions of this Agreement. Members covered under this Agreement are subject to all of the conditions and provisions contained herein and in the incorporated documents.

2. **Access to Providers.** Members can receive Basic Plan Benefits from any licensed Provider (as defined in the EOC) that is eligible to receive payment under Original Medicare (as defined in the EOC), agrees to treat the Member and accepts the Aetna Medicare Open Private Fee-for-Service Terms and Conditions of participation. This Plan does not require a contracted Provider Network and Providers are not required to treat Members, except in emergency and urgent situations.

VII. LIMITATIONS

The rights of Members and obligations of AETNA and Providers under this Agreement are subject to the following limitations:

A. Major Disaster or Epidemic.
In the event of any major disaster or epidemic that would severely limit the ability of participating physicians, providers and/or Hospitals to provide health care services on a timely basis, participating physicians, participating Hospitals and providers shall, in good faith, use their best efforts to render the benefits and services covered insofar as practical according to their best judgment and within the limitation of such facilities and personnel as are then available. If AETNA participating physicians, participating Hospitals and providers shall have, in good faith, used their best efforts to render benefits and services in the aforesaid manner, they shall have no further liability or obligation for delay or failure to provide such benefits and services due to a shortage of available facilities or personnel resulting from such disaster or epidemic.

B. Circumstances Beyond AETNA or Provider Control.
In the event that, due to circumstances not reasonably within the control of AETNA, or Providers such as the complete or partial destruction of facilities because of war, riot, civil insurrection, or the rendering of benefits and services covered hereunder is delayed or rendered impractical, neither AETNA nor any Provider shall have any liability or obligation on account of such delay or such failure to provide such benefits and services if they shall have, in good faith, used their best efforts to render the benefits and services covered insofar as practical according to their best judgment and within the limitation of such facilities and personnel as are then available.

C. Limitations as Set Out in the Evidence of Coverage and Summary of Benefits.
The benefits provided in the Plan are also limited by the limitations and exclusions as set out in the Evidence of Coverage.

D. Non-Covered Services.
AETNA shall not be responsible for the reimbursement for services or treatment of complications that result from any non-covered service, procedure or treatment. AETNA shall not be responsible for prescription drugs and/or medications related to any non-covered service, procedure or treatment.

VIII. MISCELLANEOUS

A. Records and Information

1. Aetna agrees to maintain the enrollment records received by Aetna from the Group in accordance with applicable laws, rules and regulations, and to maintain such records for the longer of: (i) a period of ten (10) years from the end of the final contract period of any government contract of AETNA to offer this Plan, (ii) the date the U.S. Department of Health and Human Services, the Comptroller General or their designees complete an audit, or (iii) the period required by applicable laws, rules or regulations (the "Record Retention Period"). The Group agrees to maintain for the duration of the Record Retention Period any additional enrollment or billing records it may receive or develop in respect to the Plan that are not provided to Aetna This Provision shall survive the termination of this Agreement, regardless of the cause of the termination.

   The Group agrees to provide federal, state and local governmental authorities having jurisdiction, directly or through their designated agents (collectively "Government Officials"), upon request, access to all books, records and other papers, documents, materials and other information (including, but not limited to, contracts and financial records), whether in paper or electronic format, relating to the arrangement described in this Agreement. The Group agrees to provide AETNA and Government Officials with access to such information for as long as it is maintained as provided in the "Records" section above. This Provision shall survive termination of this Agreement, regardless of the cause of termination.

   AETNA shall have the right, at any reasonable time, to examine the Group's records, including payroll records of employers having employees covered through the Group, with respect to eligibility and monthly payments under this Agreement.

2. Information from medical records of Members and information received from physicians or providers or facilities incident to the physician-patient provider-patient or facility-patient relationship shall be kept confidential in accordance with all applicable state and federal requirements including but not limited to HIPAA. Such information, except as reasonably necessary in connection with the administration of this Agreement, or as required by law, may not be disclosed without the written consent of the Member.

3. For the purposes of administering the Plan, AETNA may, to the extent legally allowable and without further consent of or notice to any Member, release to or obtain from any insurance company or other organization or person any information, with respect to any person, that AETNA deems to be necessary for such purposes. Any person claiming benefits under the Plan shall furnish to AETNA such information as may be necessary to implement the Plan.

4. The Application completed by Member authorizes any physician, health professional or facility to make such records, photographs or information available to AETNA as AETNA may reasonably request on behalf of Member.

B. Telephone.

The telephone number of AETNA is 1-800-282-5366. The TDD number for the hearing impaired is 1-800-628-3323. The facsimile number of AETNA is 1-888-665-6296.

C. Assignment.
Neither party to this Agreement shall assign or transfer its rights, duties or obligations under this Agreement without the prior written consent of the other party. Other than as expressly provided by this Agreement, any attempted assignment, by operation of law or otherwise, shall be void and unenforceable. This Agreement shall inure to the benefit of and shall bind the successors and permitted assignees of the parties hereto. The benefits to a Member under this Agreement are personal to the Member and are not assignable or otherwise transferable.

D. Severability.
The invalidity or unenforceability of any term or condition hereof shall in no way affect the validity or enforceability of any other term or provision hereof.

E. Incorporation by Reference.
The Evidence of Coverage, the Application and any Amendments to any of the foregoing attached hereto, form a part of this Agreement as if fully set forth herein. Any direct conflict or ambiguity between this Agreement and the EOC will be resolved under terms most favorable to the Member.

F. Authority.
Any alteration or revision to this Agreement must be in writing, signed by an officer of AETNA and an official of Group and attached to the affected form to be valid. No other person has the authority to change this Agreement or to waive any of its provisions.

G. List of Providers of Services.
From time to time, AETNA will provide to the Group for dissemination to Members a list of providers who provide the services and benefits covered under this Agreement.

H. Furnishing Information.
Any person claiming or who may claim benefits under the Plan shall facilitate the access of or furnish to AETNA such information as may be necessary to implement this Agreement, and AETNA may release or obtain such information as needed to implement the provisions of this Agreement.

I. Independent Agents.

1. The relationships between AETNA and participating facilities is that of independent contractors. Participating facilities are not agents or employees of AETNA nor is AETNA an employee or agent of any participating facility. Participating facilities shall maintain the facility-patient relationship with Members and shall be the only parties responsible to Members for the services that they provide.

2. The relationship between AETNA and physicians and other health professionals is that of independent contractors. Physicians and health professionals are not agents or employees of AETNA, nor is AETNA or any employee of AETNA an employee or agent of any physician or health professional. Physicians and health professionals shall maintain the physician-patient or health professional-patient relationship with Members.

3. Neither the Group nor any Member thereof is the agent or representative of AETNA, and neither shall be liable for any acts or omissions of AETNA, its agents or employees, any physician, any provider, or any other person or organization with which AETNA has made or hereafter shall make arrangements for the performance of services under this Agreement.

J. Provider Communication.
AETNA will not prohibit, attempt to prohibit or discourage any physician or health professional from discussing or communicating to a Member or a Member's designee any information or opinions regarding the Member's health care, any provisions of the Plan as it relates to the medical needs of the Member or the fact that the physician or health professional's contract with the AETNA has terminated or that the physician or health professional will no longer be providing services under the AETNA.

K. State Law.
If this Agreement contains any provision not in conformity with Texas state law or other applicable laws it shall not be rendered invalid but shall be construed and applied as if it were in full compliance according to applicable Texas state law and other applicable laws.

L. Incontestability.
All statements made by a Member are considered representations and not warranties. A statement may not be used to void, cancel, or non-renew a Member's Coverage or reduce benefits unless it is in a written enrollment Application signed by the Member and a signed copy of the enrollment Application has been furnished to the Member. Coverage may only be contested because of fraud or intentional misrepresentation of material fact on the enrollment Application.

M. Confidentiality.
Information contained in the medical records of Members and information received from physicians, surgeons, Hospitals or other health professionals incident to the physician-patient relationship or Hospital-patient relationship shall be kept confidential in accordance with applicable law. Information may not be disclosed without the consent of the Member except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary by AETNA in connection with the administration of this Plan, or in the compiling of aggregate statistical data. Such information that is identifiable with an individual Member may not be disclosed to Group, in connection with the conduct of Appeals or otherwise, without the written consent of the affected Member.

N. Governing Law and Venue.
This Agreement shall be governed in all respects by the laws of the State of Texas, to the extent not otherwise superceded by Federal law, and venue for any court action shall lie in Harris County, Texas.

O. Waiver.
The waiver by either party of any breach of any provision of the Agreement or warranty representation herein set forth shall not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder shall not operate as a waiver of such right. All rights and remedies provided herein are cumulative.

P. Claim Determinations and Administration of Covered Benefits.

AETNA has complete authority to review all claims for covered benefits as defined in the EOC under this Agreement. In exercising such responsibility, AETNA 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 Agreement, the EOC or any other document incorporated herein. Aetna shall be deemed to have properly exercised such authority unless Aetna abuses our discretion by acting arbitrarily and capriciously. AETNA's 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. The administration of covered benefits and of any appeals filed by Members related to the processing of claims for covered benefits shall be conducted in accordance with the EOC and any applicable laws, rules and regulations

EXHIBIT II TO GROUP APPLICATION

Calculation of renewal rates:	**Considered by Aetna Life Insurance Company to be proprietary information**

COVER PAGE

AETNA LIFE INSURANCE COMPANY
MEDICARE ADVANTAGE (MA) PRIVATE FEE-FOR-SERVICE PLAN
AETNA MEDICARE OPEN^{SM} PLAN

EVIDENCE OF COVERAGE FOR CALENDAR YEAR 2007 FOR CITY OF HOUSTON

January 1, 2007—December 31, 2007

Aetna Member Services:

For help or information, please call Member Services at 1-800-282-5366/TDD # 1-800-628-3323, 8am to 8pm, 7 days per week. This number is also located on your ID card.

Translation of this material into another language may be available. For assistance, please call Member Services at 1-800-282-5366 /TDD #1-800-628-3323.

Puede estar disponible la traducción de este material en otro idioma. Por favor, para ayuda llame a Servicios al Miembro al 1-800-282-5366 /TDD #1-800-628-3323.

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AETNA LIFE INSURANCE COMPANY
151 Farmington Avenue
Hartford, CT 06156

MEDICARE ADVANTAGE (MA) PRIVATE FEE-FOR-SERVICE PLAN
AETNA MEDICARE OPEN[SM] PLAN

EVIDENCE OF COVERAGE FOR CALENDAR YEAR 2007

This Evidence of Coverage ("**Evidence of Coverage**") is between Aetna Life Insurance Company, a **Medicare Advantage (MA) Organization** herein after referred to as **Aetna,** and the **Subscriber**, herein after referred to as **Member**. This **Evidence of Coverage** is an explanation of your rights, benefits and responsibilities as a **Member** of the **Aetna** plan. **Aetna** has entered into a contract with **CMS** to provide a **MA Private Fee-For-Service (PFFS) Plan**. This contract authorizes **Aetna** to arrange for access to health services to individuals who are entitled to **Medicare** benefits and who chose to enroll with **Aetna**. **Aetna** provides coverage for all services and supplies offered by **Medicare**, plus additional services and supplies not covered by **Medicare**.

This **Evidence of Coverage** determines the terms and conditions of coverage. Provisions of this **Evidence of Coverage** include the **Enrollment Form**, Schedule of Copayments, and any **Amendments**, riders or endorsements. **Amendments**, riders or endorsements may be delivered with the **Evidence of Coverage** or added thereafter.

Aetna agrees with the **Member** to provide coverage for **Covered Benefits**, in accordance with the conditions, rights, and privileges as set forth in this **Evidence of Coverage**. **Members** covered under this **Evidence of Coverage** are subject to all the conditions and provisions of this **Evidence of Coverage**.

This **Evidence of Coverage** describes covered health care benefits. Coverage for services or supplies is provided only if it is furnished while an individual is a **Member**. This means that coverage is provided only for health care services furnished while this coverage is in force. Coverage is not provided for any services received before coverage starts or after coverage ends.

A **Member** shall be entitled to the **Covered Benefits** that would be covered by **Medicare** plus any additional services and supplies outlined in this **Evidence of Coverage**. This **Evidence of Coverage** describes the **Basic Benefits** which are all health care services that are covered under the **Medicare Part A** and **Medicare Part B** programs (except **Hospice** services).

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Unless specifically stated otherwise, in order for benefits to be covered, they must be **Medically Necessary**. For the purpose of coverage, **Aetna** may determine whether any benefit provided under the **Evidence of Coverage** is **Medically Necessary**. Preventive care will be considered **Medically Necessary**.

All **Covered Benefits** will be covered in accordance with **Medicare** guidelines and the guidelines determined by **Aetna.**

Coverage is subject to the exclusions and limitations in the Exclusions and Limitations section of this **Evidence of Coverage**. If a **Member** has questions regarding coverage under this **Evidence of Coverage**, the **Member** may call **Member Services** at the toll free telephone number which is listed on the **Member's** identification card.

If a **Member** has any questions whether **Aetna** will pay for a service, including inpatient hospital services, **Member** has the right under law to have a written/binding advance coverage determination made for the service. Call the **Member Services** department to determine if the service will be covered.

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

This **Evidence of Coverage** is not in lieu of insurance for Worker's Compensation. This **Evidence of Coverage** is governed by applicable federal law and any applicable laws of state.

Aetna does not discriminate in the employment of staff or in the provision of providing access to health care services on the basis of race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national origin. Federal law mandates that **Aetna** comply with Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, other laws applicable to recipients of federal funds, and all other applicable laws and rules.

AETNA'S BENEFITS PACKAGE, PREMIUMS, COST SHARING AND SERVICE AREA ARE ALL SUBJECT TO CHANGE ANNUALLY AT AETNA'S CONTRACT RENEWAL TIME WITH THE MEDICARE PROGRAM (USUALLY JANUARY 1). AETNA'S CONTRACT WITH CMS IS RENEWED ANNUALLY, AND THE AVAILABILITY OF COVERAGE BEYOND THE END OF THE CURRENT CONTRACT YEAR IS NOT GUARANTEED.

READ THIS ENTIRE EVIDENCE OF COVERAGE CAREFULLY. IT DESCRIBES THE RIGHTS AND OBLIGATIONS OF MEMBERS AND AETNA. IT IS THE MEMBER'S RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS EVIDENCE OF COVERAGE.

IN SOME CIRCUMSTANCES, CERTAIN MEDICAL SERVICES ARE NOT COVERED. IN ADDITION, FOR CERTAIN SERVICES, AETNA REQUESTS THAT MEMBER OBTAIN PRECERTIFICATION FROM AETNA, THOUGH PRECERTIFICATON IS NOT REQUIRED.

NO SERVICES ARE COVERED UNDER THIS EVIDENCE OF COVERAGE IN THE ABSENCE OF PAYMENT OF PLAN PREMIUMS SUBJECT TO THE PREMIUM GRACE PERIOD PROVISION OF THIS EVIDENCE OF COVERAGE.

THIS EVIDENCE OF COVERAGE 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 EVIDENCE OF COVERAGE.

NO PROVIDER, INSTITUTION, FACILITY OR AGENCY IS AN AGENT OR EMPLOYEE OF AETNA.

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AETNA LIFE INSURANCE COMPANY
TEXAS

AETNA MEDICARE OPEN[SM] PLAN

GROUP SCHEDULE OF COPAYMENTS/COINSURANCE

Contract Holder Name: CITY OF HOUSTON
Contract Holder Group Agreement Effective Date: JANUARY 1, 2007
Contract Holder Number:

BENEFITS

Benefit	Deductible Amount and Out-of-Pocket Maximum
Deductible Amount	None
Calendar Year Out-of-Pocket Maximum	None

Aetna requests Precertification for certain services. Please refer to the Evidence of Coverage for a list of services.

OUTPATIENT BENEFITS

Benefit	Copayment/Coinsurance
Primary Physician Office Visit	
Office Hours	**$15 per visit**
Home or After-Office Hours Visit	**$15 per visit (does not apply in CA)**
Preventive Care*	**$0 per visit**
Inpatient Visit	**$15 per visit**
Immunizations: **Copayment/Coinsurance** is waived for immunizations for flu, pneumonia and Hepatitis B.	**$0 per visit**

Aetna requests Precertification for certain services. Please refer to the Evidence of Coverage for a list of services.

***Preventive Care includes routine physical, bone mass measurement, colorectal screening exams, prostate screening exams, pelvic exam, mammography, and pap smear.**

OUTPATIENT BENEFITS
(continued)

Benefit	Copayment/Coinsurance
Specialist Physician Office Visit	**$15 per visit**
Routine Gynecological Exam **1 exam per calendar year**	**$0 per visit**
Inpatient Visit	**$15 per visit**
Chiropractic Visit Manual manipulation of the spine only to the extent covered by **Medicare**	**$15 per visit**
Vision Exam Diagnostic Vision Exam Routine- 1 exam per cal year	**$0 per visit**
Hearing Exam Diagnostic Hearing Exam Routine- 1 exam per cal year	**$0 per visit**
Podiatry Visit Medically Necessary Visit	**$15 per visit**

Aetna requests Precertification for certain services. Please refer to the Evidence of Coverage for a list of services.

OUTPATIENT BENEFITS
(continued)

Benefit	Copayment/Coinsurance
Outpatient Rehabilitation Benefits (Outpatient Physical Therapy, Occupational Therapy, Speech and Language Therapy)	**$15 per visit**
Outpatient Chemotherapy, Dialysis and Radiation	**$15 per visit**
Dialysis	**$15 per visit**
Diagnostic Laboratory, X-Ray and Nuclear Testing	**$15 per visit (does not apply in CA)**
PET Scans, CAT Scans, MRI tests	**$15 per visit**
Outpatient Emergency Services and Urgently Needed Care Services (Emergency Services copayment/coinsurance is waived if admitted)	**$35 per visit**
Outpatient Urgently Needed Care Services	**$35 per visit**
Ambulance	**$15 per trip**
Outpatient Mental Health Visits	**$25 per visit**
Outpatient Substance Abuse Visits	**$15 per visit**
Outpatient Surgery	**$0**
Outpatient Home Health Visits	**$0 per visit**

Diabetes Self-Monitoring Equipment and Supplies	**$0**
Durable Medical Equipment	**15% per item**
Prosthetic Devices	**15% per item**
Medicare Covered Injectables and Medicare Covered Oral Drugs (only those injectables and drugs required to be covered by Medicare)	**$0**

Aetna requests Precertification for certain services. Please refer to the Evidence of Coverage for a list of services.

INPATIENT BENEFITS

Benefits	Copayment/Coinsurance
Hospital Care	**$0 per admission**
Transplants	**For inpatient transplant hospital services, the Hospital Care cost sharing listed above applies.** **For all other transplant services (i.e. outpatient diagnostic, lab, X-ray, outpatient physician visits, etc.) the Member cost sharing is based on the type of service provided.**
Mental Health **Combined maximum of 190 days per lifetime for all inpatient mental health and Detoxification and Rehabilitation substance abuse treatment in a Medicare-Certified Psychiatric Hospital.** (Inpatient services in a general hospital have no maximum day limit.)	**$0 per admission**
Substance Abuse **Detoxification** **Rehabilitation** **Combined maximum of 190 days per lifetime for all inpatient mental health and Detoxification and Rehabilitation substance abuse treatment in a Medicare-Certified Psychiatric Hospital.** (Inpatient services in a general hospital have no maximum day limit.)	**$0 per admission** **$0 per admission** **$0 per admission**
Skilled Nursing Facility- 100 days per benefit period (A prior Hospital confinement is not required.)	**$0 per day for days 1-10** **$25 per day for days 11-20** **$50 per day for days 21-100**

ADDITIONAL BENEFITS

Benefit	Copayment/Coinsurance
Prescription Lens and Frame Refer to the Covered Benefits Section of the **Evidence of Coverage** for coverage of post-cataract lenses.	**Lens Discounts** This program provides you with access to discounts on eyewear at participating Provider locations.
Hearing Aid **A Statement of Satisfaction Form must be signed by the Member and Provider and submitted to Aetna to obtain reimbursement. Contact Member Services to obtain a form.** Refer to Attachment D "Hearing Aid Rider" for a description of the hearing aid benefit.	**$500 reimbursement every 36 months**

Aetna requests Precertification for certain services. Please refer to the Evidence of Coverage for a list of services.

For full information on the benefits provided under this Schedule of Copayments/Coinsurance, please refer to your Evidence of Coverage, or call the Member Services Department at 1-800-282-5366 (TDD:1-800-628-3323). This number is also located on the ID card.