Aetna U.S. Healthcare Inc.
**(**Washington**)**

## CERTIFICATE OF COVERAGE

This Certificate of Coverage (**"Certificate"**) is part of the **Group Agreement** (**"Group Agreement"**) between Aetna U.S. Healthcare 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 the State of Washington.**

**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.**

**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 OR 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.**

## AVAILABLE INFORMATION

**WASHINGTON LAW REQUIRES HMO TO PROVIDE, UPON REQUEST, THE FOLLOWING INFORMATION: (A) A LISTING OF COVERED BENEFITS, INCLUDING PRESCRIPTION DRUG BENEFITS, IF ANY, A COPY OF THE CURRENT FORMULARY, IF ANY IS USED, DEFINITIONS OF TERMS SUCH AS GENERIC VERSUS BRAND NAME, AND POLICIES REGARDING COVERAGE OF DRUGS, SUCH AS HOW THEY BECOME APPROVED OR TAKEN OFF THE FORMULARY, AND HOW CONSUMERS MAY BE INVOLVED IN DECISIONS ABOUT BENEFITS; (B) A LISTING OF EXCLUSIONS, REDUCTIONS, AND LIMITATIONS TO COVERED BENEFITS, AND ANY DEFINITION OF MEDICAL NECESSITY OR OTHER COVERAGE CRITERIA UPON WHICH THEY MAY BE BASED; (C) A STATEMENT OF AETNA HEALTH INC.'S POLICIES FOR PROTECTING THE CONFIDENTIALITY OF HEALTH INFORMATION; (D) A STATEMENT OF THE COST OF PREMIUMS AND ANY MEMBER COST-SHARING REQUIREMENTS; (E) A SUMMARY EXPLANATION OF AETNA HEALTH INC.'S GRIEVANCE PROCESS; (F) A STATEMENT REGARDING THE AVAILABILITY OF A POINT-OF-SERVICE OPTION, IF ANY, AND HOW THE OPTION OPERATES; AND (G) A CONVENIENT MEANS OF OBTAINING LISTS OF PARTICIPATING PRIMARY CARE AND SPECIALTY CARE PROVIDERS, INCLUDING DISCLOSURE OF NETWORK ARRANGEMENTS THAT RESTRICT ACCESS TO PROVIDERS WITHIN ANY PLAN NETWORK.**

**MEMBERS WILL RECEIVE THE DISCLOSURE INFORMATION REFERENCED ABOVE IN THEIR ENROLLMENT PACKETS. SOME ITEMS OF INFORMATION SUCH AS THE LISTING OF COVERED BENEFITS, EXCLUSIONS, REDUCTIONS AND LIMITATIONS TO COVERED BENEFITS ARE ALSO PROVIDED IN THIS CERTIFICATE AND THE ATTACHED SCHEDULES OF BENEFITS. MEMBERS WISHING TO OBTAIN ADDITIONAL COPIES OF THE ABOVE REFERENCED INFORMATION, AND ADDITIONAL INFORMATION ABOUT THEIR PLAN MAY CONTACT MEMBER SERVICES AT THE TOLL-FREE NUMBER LISTED ON THEIR ID CARD.**

**Contract Holder**: Seattle School District
**Contract Holder** Number: 056659
**Contract Holder Group Agreement** Effective Date: October 1, 2003

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## HMO PROCEDURE

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

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

B. **The Primary Care Provider.**

The **PCP** coordinates a **Member's** medical care, as appropriate, either by providing treatment or by issuing **Referral**s 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 a **Medical Emergency** or for certain direct access **Specialist** benefits as described in this **Certificate**, only those services which are provided by or referred by a **Member's PCP** will be covered. **Covered Benefits** are described in the **Covered Benefits** section of this **Certificate**. It is a **Member's** responsibility to consult with the **PCP** in all matters regarding the **Member's** medical care.

Certain **PCPs** may be 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 the **PCP's** system or group. However, if the **PCP's** integrated delivery system does not include a **Provider** qualified to meet the **Member's** medical needs, the **Member** may be referred outside the **PCP's** integrated delivery system. **Members** may call their **PCP's** office to find out if a particular **Specialist** or facility is affiliated with their **PCP**. **Members** may also call Member Services at the toll-free number on their ID card to find out which **PCPs** a particular **Specialist** or facility is affiliated with.

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 **Medical Emergency** care.

D. **Changing a PCP.**

A **Member** may change their **PCP** at any time by calling the Member Services toll-free telephone number listed on the **Member's** identification card or by written or electronic submission of the **HMO's** change form. A **Member** may contact **HMO** to request a change form or for assistance in completing that form. The change will become effective upon **HMO's** receipt and approval of the request, but not later than the first of the month following the date of receipt of the request for the **PCP** change.

E. **Ongoing Reviews.**

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

F. **Pre-Authorization.**

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

## METHOD OF PAYMENT

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

**The Deductible.**

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

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

**Maximum Out-of-Pocket Limit.**

If a **Member's Copayments**, plus the **Deductible**, reach the Maximum Out-of-Pocket Limit set forth on the Schedule of Benefits, **HMO** will pay 100% of the contracted charges for **Covered Benefits** for the remainder of that calendar year, up to the Maximum Benefit listed on the Schedule of Benefits. **Covered Benefits** must be rendered to the **Member** during that calendar year.

**Benefit Limitations.**

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

**Calculations; Determination of Benefits.**

A **Member's** financial responsibility for the costs of services will be calculated on the basis of when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of stays that occur in more than 1 calendar year. It is solely within the discretion of **HMO** to determine when benefits are covered under this **Certificate**.

## ELIGIBILITY AND ENROLLMENT

A. **Eligibility.**

1. To be eligible to enroll as a **Subscriber**, an individual must:

a. meet all applicable eligibility requirements agreed upon by the **Contract Holder** and **HMO**; and

b. live or work in the **Service Area**.

2. To be eligible to enroll as a **Covered Dependent**, the **Contract Holder** must provide dependent coverage for **Subscribers**, and the dependent must be:

a. the legal spouse of a **Subscriber** under this **Certificate**; or

b. a dependent unmarried child (including natural, foster, step, legally adopted children, children placed for adoption, a child under court order, ) who meets the eligibility requirements described in this **Certificate** and on the Schedule of Benefits.

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 60 days from the date of birth. To continue coverage beyond this initial period if additional premium is required, the child must be enrolled in **HMO** and the initial **Premium** paid within the first 60 days after birth. If coverage does not require the payment of an additional **Premium** for a **Covered Dependent**, the **Subscriber** is encouraged to call Member Services at the toll-free number listed on the ID Card and enroll the child within 60 days after the date of birth to facilitate claims payment.

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

b. Adopted Children.

A legally adopted child or a child for whom a **Subscriber** is a court appointed legal guardian, and who meets the definition of a **Covered Dependent**, will be treated as a dependent from the date of adoption or upon the date the child was placed for adoption with the **Subscriber**. "Placed for adoption" means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The **Subscriber** must make a written request for coverage within 60 days of the date the child is adopted or placed with the **Subscriber** for adoption if payment of an additional premium is required.

4. Special Rules Which Apply to Children.

a. Qualified Medical Child Support Order.

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

b. Handicapped Children.

Coverage is available for a child who is chiefly dependent upon the **Subscriber** for support and maintenance, and who is 19 years of age or older but incapable of self-support due to mental or physical incapacity. The incapacity must have commenced prior to the age the dependent would have lost eligibility. In order to continue coverage for a handicapped child, the **Subscriber** must provide evidence of the child's incapacity and dependency to **HMO** within 31 days of the date the child's coverage would otherwise terminate. Proof of continued incapacity, including a medical examination, must be submitted to **HMO** as requested, but not more frequently than annually beginning after the 2 year period following the child's attainment of the age specified on the Schedule of Benefits. This eligibility provision will no longer apply on the date the dependent's incapacity ends.

5. Notification of Change in Status.

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

6. Special Enrollment Period

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

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

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

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

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

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

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

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

Loss of eligibility includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing. Loss of eligibility does not include a loss due to failure of the individual or the participant to pay **Premiums** on a timely basis or due to termination of coverage for cause as referenced in the Termination of Coverage section of this **Certificate**; and

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

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

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

**Special Enrollment Period When a New Eligible Dependent is Acquired:**

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

The special enrollment period is a period of 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**.

C. **Effective Date of Coverage.**

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

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

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

## COVERED BENEFITS

A **Member** shall be entitled to the **Covered Benefits** as specified below, in accordance with the terms and conditions of this **Certificate**. Unless specifically stated otherwise, in order for benefits to be covered, they must be **Medically Necessary**. For the purpose of coverage, **HMO** may determine whether any benefit provided under the **Certificate** is **Medically Necessary**, and **HMO** has the option to only authorize coverage for a **Covered Benefit** performed by a particular **Provider**. Female **Members** have direct access to their choice of **Participating Women's Health Care Specialists** for covered women's health care services without a prior **Referral** from the **Member's Primary Care 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 maternity care and services where the **Participating Provider**, in consultation with the mother/**Member**, makes the decision on the length of inpatient stay and type and location of follow-up care, rather than making such decisions through agreements between **Providers**, **Hospitals** and **HMO.**

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

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

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

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

- information provided on the **Member's** health status;

- reports in peer reviewed medical literature;

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

- professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;
- the opinion of **Health Professionals** in the generally recognized health specialty involved;
- the opinion of the attending **Physicians**, which have credence but do not overrule contrary opinions; and
- any other relevant information brought to **HMO's** attention.

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

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

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

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

A. **Primary Care Physician Benefits.**

1. Office visits during office hours.

2. Home visits.

3. After-hours **PCP** services. **PCPs** are required to provide or arrange for on-call coverage 24 hours a day, 7 days a week. If a **Member** becomes sick or is injured after the **PCP's** regular office hours, the **Member** should:

   a. call the **PCP's** office;

   b. identify himself or herself as a **Member**; and

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

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

4. **Hospital** visits.

5. Periodic health evaluations to include:

   a. well child care from birth including immunizations and booster doses of all immunizing agents used in child immunizations which conform to the standards of the Advisory Committee on Immunization Practices of the Centers for Disease Control, U.S. Department of Health and Human Services;

   b. routine physical examinations;

   c. routine gynecological examinations, including Pap smears, for routine care, administered by the **PCP**. The **Member** may also go directly to a **Participating Women's Health**

**Care Specialist** without a **Referral** for routine GYN examinations and Pap smears. See the Direct Access Specialist Benefits section of this **Certificate** for a description of the services which may be provided by **Women's Health Care Specialists** without prior **PCP Referral** or pre-authorization;

d. routine hearing screenings;

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

f. routine vision screenings.

6. Injections, including allergy desensitization injections.

7. Casts and dressings.

8. Health Education Counseling and Information.

B. **Diagnostic Services Benefits.**

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

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

2. Mammograms, by a **Participating Provider**. The **Member** is required to obtain a **Referral** from her **PCP** or **Women's Health Care Specialist**, or obtain pre-authorization from **HMO** to a **Participating Provider**.

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

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

C. **Specialist Or Health Professional Benefits.**

**Covered Benefits** include outpatient and inpatient services.

If a **Member** is diagnosed with complex or serious medical condition or serious or complex **Mental or Behavioral Condition** (if covered), the **Member** may receive a standing **Referral** to an appropriately qualified **Participating Specialist** for **Covered Benefits**. If the **PCP** in consultation with an **HMO** Medical Director and the **Specialist** determines that a standing **Referral** is warranted, the **PCP** shall make the **Referral** to the **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 from a **Participating Provider** of the **Member's** choice, regarding a medical diagnosis, proposed surgery or course of treatment recommended by **Member's PCP** or a **Specialist**. Second opinions must be obtained from a **Participating Provider**. To request a second opinion, **Member** should contact their **PCP** for a **Referral**.

D. **Direct Access Specialist Benefits.**

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

- **Routine Gynecological Examination(s).** Routine gynecological visit(s) and Pap smear(s). The maximum number of visits, if any, is listed on the Schedule of Benefits.

- **Direct Access to Women's Health Care Specialists.** Benefits are provided to female **Members** for services performed by a **Participating Women's Health Care Specialist** for preventive gynecological care, diagnosis and treatment of gynecological problems, maternity care, and reproductive services to the extent they are covered under this **Certificate**. If the **Member** self-refers to a **Participating Women's Health Care Specialist** for one of the conditions listed above, and the **Participating Women's Health Care Specialist** diagnoses an additional health problem during the course of the visit, covered services provided during the course of the visit to treat the additional health problem will also be covered. Covered, **Medically Necessary** laboratory services, imaging services, diagnostic services or prescription drugs or supplies (to the extent they are covered under this **Certificate**) ordered by the **Participating Women's Health Care Specialist** will also be covered without prior **Referral** from the **Member's PCP**. Certain **Covered Benefits** require preauthorization by **HMO** whether provided by the **Member's PCP** or **Women's Health Care Specialist**. See the **Infertility** Services section of this **Certificate** for a description of covered **Infertility** services.

- **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

- Routine Eye Examinations, including refraction, as follows:

  1. if the **Member** is age 1 through 18 and wears eyeglasses or contact lenses, 1 exam(s) every 12-month period.

  2. if the **Member** is age 19 and over and wears eyeglasses or contact lenses, 1 exam(s) every 24-month period.

  3. if the **Member** is age 1 through 45 and does not wear eyeglasses or contact lenses, 1 exam(s) every 36-month period.

  4. if the **Member** is age 46 and over and does not wear eyeglasses or contact lenses, 1 exam(s) every 24-month period.

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

Outpatient and inpatient pre-natal and postpartum care and obstetrical services (including but not limited to **Medically Necessary** pre-natal counseling and diagnosis of genetic and congenital disorders) provided by **Participating Providers** are a **Covered Benefit**. To be covered for these benefits, the **Member** is requested to choose either her **PCP**, or a **Participating Women's Health Care Specialist** from **HMO's** list of **Participating Women's Health Care Specialists**, and inform **HMO** by calling the Member Services toll-free telephone number listed on the **Member's** identification card, prior to receiving services. The **Member's PCP** or **Participating Women's Health Care Specialist** is responsible for obtaining any required pre-authorizations for all non-routine obstetrical services from **HMO** after the first prenatal visit.

Coverage does not include routine maternity care (including delivery) received while outside the **Service Area** unless the **Member** receives pre-authorization from **HMO**. However, if the **Member's** health care **Provider** was consulted prior to travel, and determined that travel outside the **Service Area** posed no danger, coverage will include **Covered Benefits** for premature birth expenses. As with any other medical condition, **Emergency Service**s are covered when **Medically Necessary**.

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

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

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

3. a longer **Hospital** stay as determined by the attending health care **Provider**, in consultation with the mother, based on clinical information that demonstrates that the mother and infant are clinically stable based on nationally accepted guidelines for perinatal care, such as Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, and that appropriate care for the mother and newborn can be provided for upon discharge; or

4. 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.

5. The type and location of any follow-up care must be made by the attending health care **Provider**, in consultation with the mother, and will be based on accepted medical practice and be **Medically Necessary**. **Covered Benefits** may not be denied for follow-up care, when ordered by the attending health care **Provider**, in consultation with the mother.

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 payment to the **Hospital** or **Skilled Nursing Facility** for such additional **Hospital**, **Skilled Nursing Facility**, **Physician** and other **Provider** services, and **HMO** shall not be financially responsible for such additional services.

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

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

G. **Transplants.**

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

H. **Outpatient Surgery Benefits.**

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

I. **Substance Abuse Benefits.**

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

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

   **Member** is entitled to outpatient visits to a **Participating Behavioral Health Provider** upon **Referral** by the **PCP** for diagnostic, medical or therapeutic **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 Condition**s 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 (1) inpatient day, if any, may be exchanged for 2 days of treatment in a **Partial Hospitalization** and/or outpatient electroshock therapy (ECT) program in lieu of hospitalization up to the maximum benefit limitation upon approval by **HMO**.

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

**Washington State Regulation 284-43-810 requires the inclusion of the following information in this Certificate.**

## MENTAL HEALTH SERVICES AND YOUR RIGHTS

Aetna U.S. Healthcare Inc. and state law have established standards to assure the competence and professional conduct of mental health service providers, to guarantee your right to informed consent to treatment, to assure the privacy of your medical information, to enable you to know which services are covered under this plan and to know the limitations on your coverage. If you would like a more detailed description than is provided here of covered benefits for mental health services under this plan, or if you have a question or concern about any aspect of your mental health benefits, please contact us at the toll free number listed on your ID Card.

If you would like to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract or your rights under the law, you may contact the Office of Insurance Commissioner at 800-562-6900. If you have a concern about the qualifications or professional conduct of your mental health service provider, please call the State Health Department at 1-800-525-0127.

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

1. **Emergency Care:** A **Member** is covered for **Emergency Services**, provided the service is a **Covered Benefit**. **HMO** will:

   a. cover **Emergency Services** necessary to screen and stabilize a **Member** if a prudent layperson acting reasonably would believe that an emergency medical condition exists. Prior authorization provided prior to the point of stabilization is not required, provided a prudent layperson acting reasonably would believe that a **Medical Emergency** exists.

   b. with regard to care obtained from a non-participating **Hospital** emergency room, cover **Emergency Services** necessary to screen and stabilize a **Member** if a prudent layperson would have reasonably believed that use of a **Participating Hospital** emergency room would result in a delay that would worsen the condition. Pre-authorization provided prior to the point of stabilization is not required, provided a prudent layperson acting reasonably would believe that a **Medical Emergency** exists and that use of a **Participating Hospital's** emergency room would result in a delay that would worsen the condition.

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

   The **Member** will be reimbursed for the cost for **Emergency Services** rendered by a non-participating **Provider** located either within or outside the **HMO Service Area**, for those expenses, less **Copayments**, which are incurred up to the time the **Member** is determined by **HMO** and the attending **Physician** to be medically able to travel or to be transported to a **Participating Provider**. In the event that transportation is **Medically Necessary**, **HMO** will make all the transportation arrangements and will pay the transfer expenses, minus any applicable **Copayments**.

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

2. **Urgent Care:**

   - **Urgent Care Inside the Service Area.** If the **Member** urgently needs services while inside the **Service Area**, but the **Member's** 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 unavailable the **Member** may access care from a **Participating Urgent Care** facility inside the **Service Area** if:
     a. the service is a **Covered Benefit**;

b. the service is **Medically Necessary** and immediately required because of an unforeseen illness, injury, or condition; and
c. the **Member's PCP** is not available.

- **Urgent Care Outside the Service Area**. The **Member** will be covered for **Urgent Care** services obtained from a licensed **Provider** or facility outside of the **Service Area** if:
  a. the service is a **Covered Benefit**;
  b. the service is **Medically Necessary** and immediately required because of unforeseen illness, injury, or condition; and
  c. it was not reasonable, given the circumstances, for the **Member** to return to the **HMO Service Area** for treatment.

3. A **Member** is covered for any follow-up care. Follow-up care is any care directly related to the need for **Emergency Services** which is provided to a **Member** after the **Medical Emergency** or **Urgent Care** situation has terminated. All follow-up and continuing care must be provided or arranged by a **Member's PCP**. The **Member** must follow this procedure, or the **Member** will be responsible for payment for all services received.

L. **Outpatient Rehabilitation Benefits.**

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

7. Neurodevelopmental Therapy. Neurodevelopmental therapy is covered for **Members** age six and under. Treatment includes speech therapy or physical therapy given to restore or improve a speech or body function; or to develop a speech or body function delayed by a neurological disease; or to maintain a speech or body function if, without therapy, a neurological disease would cause significant deterioration in the **Member's** condition. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.

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 Provider**. **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; **Respite Care** that is continuous care in the most appropriate setting for a maximum of five (5) days per three (3) month period of **Hospice Care**, and other **Home Health Services** listed in the Home Health Benefits section of this **Certificate**.

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

O. **Prosthetic Appliances Benefits.**

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

P. **Injectable Medications Benefits.**

Injectable medications, including those medications intended to be self administered, are a **Covered Benefit** when an oral alternative drug is not available, unless specifically excluded as described in the Exclusions and Limitations section of this **Certificate**. Medications must be prescribed by a **Provider** licensed to prescribe federal legend prescription drugs or medicines, and 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 one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American **Hospital** Formulary Service Drug Information) and the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer reviewed journal.

Q. **Reconstructive Breast Surgery Benefits.**

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

R. **Additional Benefits.**

- **Durable Medical Equipment Benefits.**

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

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

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

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

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

## EXCLUSIONS AND LIMITATIONS

A. **Exclusions.**

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

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

- Beam neurologic testing.

- Biofeedback, except as pre-authorized by **HMO**.

- Blood and blood plasma, including but not limited to, provision of blood, blood plasma, blood derivatives, synthetic blood or blood products other than blood derived clotting factors, the collection or storage of blood plasma, the cost of receiving the services of professional blood

donors, apheresis or plasmapheresis. Only administration, processing of blood, processing fees, and fees related to autologous blood donations are covered.

- Care for conditions that state or local law require to be treated in a public facility, including but not limited to, mental illness commitments.

- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.

- **Cosmetic Surgery**, or treatment relating to the consequences of, or as a result of, **Cosmetic Surgery**, other than **Medically Necessary** Services. This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty, except when determined to be **Medically Necessary** by an **HMO** Medical Director, is not covered. This exclusion does not apply to surgery to correct the results of injuries causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate and breast reconstructive surgery resulting from a mastectomy that was **Medically Necessary**. In the case of a congenital defect that affects appearance, a defect will be considered to exist if the **Member's** appearance resulting from such condition is not within the range of normal human variation.

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

- Court ordered services, or those required by court order as a condition of parole or probation.

- **Custodial Care.**

- Dental services, including but not limited to, services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, dental services related to the gums, apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, alveolectomy, augmentation and vestibuloplasty treatment of periodontal disease, false teeth, prosthetic restoration of dental implants, and dental implants. This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors, and orthodontogenic cysts.

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

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

  This exclusion will not apply with respect to drugs:

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

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

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.

- Implantable drugs.

- The treatment of male or female **Infertility**, including but not limited to:
  1. The purchase of donor sperm and any charges for the storage of sperm;
  2. The purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers;
  3. Charges associated with cryopreservation or storage of cryopreserved embryos (e.g., office, **Hospital**, ultrasounds, laboratory tests, etc.);
  4. Home ovulation prediction kits;
  5. Injectable **Infertility** medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
  6. Artificial Insemination, in vitro fertilization (IVF), gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), and intracytoplasmic sperm injection (ICSI), and any other advanced reproductive technology ("ART") procedures or services related to such procedures;
  7. Any charges associated with care required for ART (e.g., office, **Hospital**, ultrasounds, laboratory tests, etc.);
  8. Donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
  9. Any charges associated with a frozen embryo transfer, including but not limited to thawing charges;
  10. Reversal of sterilization surgery; and
  11. Any charges associated with obtaining sperm for any ART procedures.

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

- Missed appointment charges.

- Non-Medically Necessary services, including but not limited to, those services and supplies:

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

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

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

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

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

- Orthotics.
- Outpatient supplies, including but not limited to, medical consumable or disposable supplies such as incontinence pads, elastic stockings, but not including Phenyl-free and Lofenalac formulas for the dietary treatment of phenylketonuria when recommended by a **Physician** or other qualified **Health Professional**.
- Payment for that portion of the benefit for which Medicare or another party payer is the primary payer.
- Personal comfort or convenience items, including those services and supplies not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other like items and services.
- 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. drugs related to the treatment of non-covered services; and

    3. drugs related to the treatment of **Infertility**, contraception, and performance enhancing steroids.

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

- Surgical operations, procedures or treatment of obesity, except when specifically pre-authorized by **HMO**.

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

- Thermograms and thermography.

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

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

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

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

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

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

- Weight reduction programs, or dietary supplements.

- Family planning services.

- Non-surgical treatment of temporomandibular joint disorder (TMJ). Temporomandibular joint disorder treatment (TMJ), including but not limited to, treatment performed by prosthesis placed

directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutics services related to TMJ.

B. **Limitations.**

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

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

## TERMINATION OF COVERAGE

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

A. **Termination of Subscriber Coverage.**

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

1. employment terminates;

2. the **Group Agreement** terminates;

3. the **Subscriber** is no longer eligible as outlined in this **Certificate** and/or on the Schedule of Benefits; or

4. the **Subscriber** becomes covered under an alternative health benefit plan or under any other plan which is offered by, through, or in connection with, the **Contract Holder** in lieu of coverage under this **Certificate**.

B. **Termination of Dependent Coverage.**

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

1. a **Covered Dependent** is no longer eligible, as outlined in this **Certificate** and/or on the Schedule of Benefits;

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

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

C. **Termination For Cause.**

**HMO** may terminate coverage for cause:

1. upon 30 days advance written notice, if the **Member** has failed to make any required **Copayment**, **Premium** payment or other payment to **HMO** which the **Member** is obligated to pay. Upon the effective date of such termination, prepayments received by **HMO** on account of such terminated **Member** or **Members** for periods after the effective date of termination shall be refunded to **Contract Holder**.

2. immediately, upon discovering a material misrepresentation by the **Member** in applying for or obtaining coverage or benefits under this **Certificate** (excluding any statements by the **Member** regarding their health status) 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. It may 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.

A **Member** may request that **HMO** conduct a grievance hearing, as described in the Grievance Procedure section of this **Certificate**, within 15 working days after receiving notice that **HMO** has or will terminate the **Member's** coverage as described in the Termination For Cause subsection of this **Certificate**. **HMO** will continue the **Member's** coverage in force until a final decision on the grievance is rendered, provided the **Premium** is paid throughout the period prior to the issuance of that final decision.

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

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

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

## 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 **Members** or **Covered Dependents** to elect to continue group coverage as follows:

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

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

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

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

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

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

4. Continuation coverage ends at the earliest of the following events:
   a. the last day of the 18-month period.
   b. the last day of the 36-month period.
   c. the first day on which timely payment of **Premium** is not made subject to the Premiums section of the **Group Agreement**.
   d. the first day on which the **Contract Holder** ceases to maintain any group health plan.
   e. the first day, 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 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 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. **Extension of Benefits While Member is Receiving Inpatient Care.**

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

1. the date of discharge from such inpatient stay;

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

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

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

5. 12 months of coverage under this extension of benefits provision.

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

C. **Continuation of Coverage During a Labor Dispute.**

If a **Subscriber's** coverage under this Plan would terminate because he or she ceases work due to a labor dispute, a **Subscriber** can arrange to continue coverage during the absence from work if the Washington Insurance Code applies. Coverage may continue for up to 6 months.
Continuation will cease when the first of these events occurs:

- The **Subscriber** fails to make the required contributions to **Contract Holder**.

- The labor dispute ends.

- The 6 month continuation period ends.

The monthly **Premium** required by **HMO** for each **Subscriber's** coverage will be the applicable rate in effect on the date the **Subscriber** ceases work. **HMO** has the right to change **Premium** rates under the terms of this Plan at any time during any continuation of coverage.

D. **Conversion Privilege.**

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

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

1. Eligibility.

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

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

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

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

If a **Covered Dependent** looses coverage under this **Certificate** because the **Subscriber's** coverage under this **Certificate** was terminated by the employer for cause, or by the **HMO** under the provisions of subsection C. "Termination for Cause" of the Termination of Coverage section of this **Certificate**, the **Covered Dependent** is eligible to convert to continuation coverage according to the terms and conditions listed in this subsection, "Conversion Privilege".

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 than 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).

## GRIEVANCE PROCEDURE

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

A**. Definitions.**

1. An "inquiry" is a **Member**'**s** request for administrative service, information, or to express an opinion, including but not limited to, denials, cancellations, terminations or renewals.

2. A "grievance" is a **Member** complaint that may or may not require specific corrective action, including but not limited to, expressions of dissatisfaction about customer service or the quality or availability of a health service, requests for reconsideration of Adverse Determinations, or request for reconsideration of a denial of coverage based on a determination that a service is **Experimental or Investigative**. Either the **Member** or the **Member's** authorized representative (who may be the **Member's** treating **Provider**) may submit a grievance orally or in writing to **HMO**.

3. "Adverse Determination" means a determination by **HMO** or its designee that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided,

- does not meet **HMO's** requirement for **Medical Necessity**, appropriateness, health care setting, level of care or effectiveness, or

- meets the criteria for the **Experimental** and **Investigative** exclusion

and the requested service or coverage is therefor denied, modified, reduced, or terminated.

An Adverse Determination does not include any determination affecting payment or coverage after the service or benefit has been provided.

B. **Adverse Determination Grievance Process.**

1. Notice of an Adverse Determination will be provided to the **Member** (or the **Member's** authorized representative) and the treating **Provider** within 2 business days of the determination and either the **Member** or the treating **Provider** may file a grievance requesting a reconsideration of the Adverse Determination. The **Member** has the right to have an uninvolved **HMO** representative assist the **Member** in understanding the grievance process.

2. The grievance requesting reconsideration of an Adverse Determination will be evaluated by a **Health Professional** who shall consult with an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. All relevant information submitted by the **Member** or by a **Provider** acting on behalf of the **Member** will be reviewed. The **Health Professional** and clinical peer(s) shall not have been involved in the initial Adverse Determination.

3. The **HMO** shall notify both the **Member** and the attending or ordering **Provider** in writing of the decision within fourteen (14) days following the receipt of the request for an appeal. The time frame for notification of the decision may be extended to 30 days if the **Member** is notified within 14 days, but in no case may the notification of the decision be more than 30 days from the receipt of the appeal without the informed, written consent of the **Member**. The written decision will contain:

   a. a statement of the **HMO's** understanding of the reason for the **Member's** grievance;

   b. the actual reasons for the **HMO's** decision;

   c. a reference to the evidence and/or documentation used as the basis for the decision, including all relevant information submitted by the **Member** or the **Provider** acting on behalf of the **Member**,

   d. the clinical review criteria used to make the determination and instructions as to how the member may obtain the clinical review criteria used to make the determination; and

   e. a description of the process of how to appeal to the Grievance Appeal Committee.

4. In any cases where the initial Adverse Determination review process does not resolve a difference of opinion between the **HMO** and the **Member** or the **Provider** acting on behalf of the **Member**, the **Member** or the **Provider** acting on behalf of the **Member** may submit a written request for an appeal hearing. The process for an appeal hearing including denials of requests for reconsideration of Adverse Determinations is described below, in the "Appeal Hearing" sub-section of this **Certificate**.

C. **Non Adverse Determination Grievance Process.**

1. For grievances which do not relate to an Adverse Determination, a written notice shall be sent by **HMO** to the **Member** within 7 days of receipt of the grievance:

   a. acknowledging each grievance;

   b. inviting the **Member** to provide any additional information to assist **HMO** in handling and deciding the grievance;

c. informing the **Member** of the **Member's** right to have an uninvolved **HMO** representative assist the **Member** in understanding the grievance process; and

d. informing the **Member** as to when a response should be forthcoming.

2. The Grievance Coordinator deciding the grievance shall not be any person who made the initial decision regarding the claim, or any person with previous involvement with the grievance. The Grievance Coordinator shall review and decide the grievance within 30 days of receipt.

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

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

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

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

d. a statement indicating:

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

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

D. **Grievance Process For Emergency or Urgently Needed Care.**

1. In the event a grievance (including an Adverse Determination), in requires specific action, and the **Member**, **Member's** treating **Provider** or **HMO** believes a delay would jeopardize the **Member's** life or materially jeopardize the **Member's** health or ability to regain maximum function, the grievance review shall be expedited.

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

3. If the issue is of an urgent nature, an **HMO** Medical Director shall review the matter and make a determination within 72 hours of receipt of the appeal.

4. An adverse decision by a Medical Director in either an emergent or urgent medical situation shall be immediately reviewed by an **HMO** Regional Medical Director or his designee. The decision of the Regional Medical Director shall be provided to the **Member** or any **Provider** acting on behalf of the **Member** by telephone and confirmed in writing within 72 hours of receipt of the appeal.

E. **Grievance Process for Experimental or Investigational Denials.**

The grievance process for Adverse Determinations and appeal process described in this section apply, when a **Member's** grievance involves services denied because they were determined to be **Experimental** or **Investigational**, except that **HMO** will notify the **Member** in writing of a benefit denial or refusal to pre-authorize services within twenty (20) working days of receipt of a fully documented appeal. A review extension by the **HMO** may be granted beyond the twenty (20) days only with the written consent of the **Member**.

F. **Appeal Hearing.**

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

2. The Grievance Appeal Committee shall be established by the Board of Directors of the **HMO** and shall be comprised of three members. The Grievance Appeal Committee shall not include any person previously involved with the grievance. An **HMO** Medical Director may serve as a member of the Committee if the Medical Director was not previously involved with the grievance.

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

4. The **Member** may attend the appeal hearing to question designated **HMO** representatives and others familiar with the **Member's** grievance appeal and to discuss their case. The **Member** may choose to be assisted or represented by a person of the **Member's** choice, and may submit written material to support their grievance appeal. The **Member** may bring a **Physician** or other expert(s) to discuss the **Member's** grievance. **HMO** may also present persons familiar with the **Member's** grievance appeal. The person the **Member** chooses to represent them may discuss the case and question persons familiar with the **Member's** grievance appeal. If the **Member** chooses to be assisted or represented by a person of the **Member's** choice to discuss the **Member's** case, then the **HMO** may also be represented. The Grievance Appeal Committee may initiate discussions with the **HMO**, the **Member** and other persons familiar with the **Member's** grievance appeal.

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

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

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

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

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

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

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

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

G. **Independent Medical Review.**

1. The **Member** may request review by a certified independent review organization of an Adverse Determination if:

   a. the **Member** has completed the grievance and appeals hearing process and the Adverse Determination has been upheld, or

   b. the **HMO** has exceeded the timelines for grievances and appeal hearings set forth above without good cause and without reaching a decision.

2. Not later than the third business day after the date the **HMO** receives a request for an independent medical review, **HMO** will provide to the Independent Medical Review Organization designated by the Office of the Insurance Commissioner:

   a. the medical records of the **Member** that are relevant to the review;

   b. documents used by **HMO** in making the determination to be reviewed;

   c. a list of each **Physician** or **Health Care Professional** who has provided care to the **Member** and who may have medical records relevant to the appeal;

   d. the treating **Provider's** recommendations; and

   e. the terms and conditions of coverage of the **Member's** plan.

3. **HMO** will make available to the **Member** and/or the **Member's** treating **Provider** copies of all materials provided to the independent review organization. The **Member** and the **Member's** treating **Provider** will make available to **HMO** any information that they provided to the independent review organization in support of their appeal.

4. If the independent medical review request involves services which the **Member** is currently receiving (for example, the **Member** is currently hospitalized and **HMO** has determined that coverage for continued inpatient care is not **Medically Necessary**) **HMO** will continue to provide coverage for the services until the independent review organization makes their decision. If the independent review organization decision upholds the **HMO's** determination, the **Member** will be responsible for the cost of the continued health care services.

5. If the independent review organization's determination overturns the **HMO's** decision the **HMO** will promptly comply with the final determination.

6. The **Member** is not responsible for any portion of the independent review organization's charges.

H. **Non-Binding Mediation.**

If the Grievance Appeal Committee fails to render a written decision within 30 working days of the conclusion of the appeal hearing, or if the **Member's** appeal has been rejected, the **Member** may submit the grievance to non-binding mediation. Such mediation will be conducted pursuant to mediation rules similar to those of the American Arbitration Association, the Center for Public Resources, the Judicial Arbitration and Mediation Service, Washington State Law with regard to procedures for mediation of health care claims, or any other rules of mediation agreed to by the parties.

I **Member's Final Process.**

If the **Member** is not satisfied with the final decision made on their grievance in this Grievance Procedure section of the **Certificate**, the **Member** may pursue the establishing of any litigation; 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 grievance resolution process of any complaint, grievance or grievance appeal.

J. **Record Retention.**

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

K. **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 grievance or appeal, except as specifically set forth in this Grievance Procedure section.

## COORDINATION OF BENEFITS

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

**Benefits Subject to this Provision:** All of the benefits provided under this **Certificate** are subject to **Coordination of Benefits**. If the **Member** has coverage under more than one plan, **HMO** recommends that the **Member** submit their claim to both plans at the same time. In that way, the proper coordinated benefits may be most quickly determined and paid.

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

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

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

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

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

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

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

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

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

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

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

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

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

3. If there is not such a court decree:

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

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

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

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

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

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

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

If the other plan does not have a provision:

1. regarding laid-off or retired employees; and

2. as a result, each plan determines its benefits after the other,

then the above paragraph will not apply.

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

If the other plan does not have a provision:

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

then the above paragraph will not apply.

H. If the preceding rules do not determine the primary plan, the **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.

**Right to Receive and Release Necessary Information.**

For the purpose of determining the applicability of and implementing this provision and any provision of similar purpose in any other plan, **HMO** may, with such consent of the **Member** as may be necessary, release to or obtain from any other insurer, organization or person any information, with respect to any **Member** which the **HMO** considers necessary for such purpose. Any **Member** claiming benefits under this plan shall furnish to the **HMO** the information necessary for such purpose.

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

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

**Payment of Benefits.**

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

**Facility of Payment.**

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

**Recovery of Overpayments.**

If the benefits paid under this **Certificate**, plus the benefits paid by other plans, exceeds the total amount of **Allowable Expenses**, **HMO** has the right to recover the amount of that excess payment if it is the secondary plan,

from among 1 or more of the following: (1) any person to or for whom such payments were made; (2) other plans; or (3) any other entity to which such payments were made. This right of recovery shall be exercised at **HMO's** discretion. A **Member** shall execute any documents and cooperate with **HMO** to secure its right to recover such overpayments, upon request from **HMO**.

**Medicare And Other Federal Or State Government Programs.**

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

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

**Active Employees and Their Dependents Who Are Eligible For Medicare.**

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

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

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

**Provision for Coordination with Medicare.**

**HMO** reserves the right to cover full benefits or to reduce benefits for any medical expenses covered under this **Certificate**. The amount **HMO** will pay will be figured so that the amount, plus the benefits under Medicare, will equal no more than 100% **Allowable Expenses**. Charges for services used to satisfy a **Member's** Medicare Part B deductible will be applied under this **Certificate** in the order received by **HMO**. Two or more charges for services received at the same time will be applied starting with the largest first. Any rules for **Coordination of Benefits**, as outlined in this **Certificate**, will be applied after **HMO's** benefits have been calculated under the rules in this section. **Allowable Expenses** will be reduced by any Medicare benefits available for those **Allowable Expenses**.

## RESPONSIBILITY OF MEMBERS

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

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

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

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

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

## GENERAL PROVISIONS

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

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

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

1. disclose all facts, to the extent permitted by federal or state law, 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. provide reports regarding the care, treatment and physical condition of the **Member** to **HMO**, or a medical, dental, or mental health professional that **HMO** may engage to assist it in reviewing a treatment or claim; and

3. permit copying of the **Member's** records by **HMO**.

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

D. **Assignment of Benefits.** All rights of the **Member** to receive coverage for services are personal to the **Member** and may not be assigned.

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

F. **Independent Contractor Relationship.**

**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.

1. 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**.

2. **Participating Providers** maintain the provider-patient relationship with **Members** and are solely responsible to **Member** for all **Medical Services** which are rendered by **Participating Providers**.

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

   a. within 15 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. within 15 days of the termination of other **Providers** to each **Subscriber**, if the **Subscriber** or any **Dependent** of the **Subscriber** who is regularly seeing the terminating **Provider**; and
   c. services rendered by a **PCP** or **Hospital** to a **Member** between the date of termination of the **Provider** Agreement and 5 business days after notification of the contract termination is mailed to the **Member** at the **Member's** last known address shall continue to be **Covered Benefits**.

4. **PCP Termination.** When a **PCP** is terminated by **HMO** without cause, **Members** may continue to access the terminating **PCP** for care for 60 days following the date of termination, or until the end of the next **Open Enrollment Period** (whichever is less) if the provider agrees to continue to provide coverage under the terms and conditions of the current contract.

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 provision of access to 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 access to services, except to refund the amount of the unearned prepaid Premiums held by **HMO**

on the date such event occurs. **HMO** is required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

H. **Confidentiality.** Information contained in the medical records of **Members** and information received from any **Provider** incident to the provider-patient relationship shall be kept confidential in accordance with applicable law. Information may be used or disclosed by **HMO** when necessary for a **Member's** care or treatment, the operation of **HMO** and administration of this **Certificate**, or other activities, as permitted by applicable law. For other purposes, information may be disclosed only with the consent of the **Member**. **Members** can obtain a copy of **HMO's** Notice of Information Practices by calling the Member Services toll-free telephone number listed on the **Member's** identification card.

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

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

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

L. **Contract Holder** hereby makes **HMO** coverage available to persons who are eligible under the Eligibility and Enrollment section of this **Certificate**. However, this **Certificate** shall be subject to amendment, modification or termination in accordance with any provision hereof, by operation of law, by filing with and approval by the 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 and supersedes all prior and contemporaneous arrangements, understandings, negotiations and discussions of the parties with respect to the subject matter, whether written or oral; and there are no warranties, representations, or other agreements between the parties except as specifically set forth in this **Certificate**. No supplement, modification or waiver of this **Certificate** shall be binding unless executed in writing by authorized representatives of the parties.

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

Q. From time to time **HMO** may offer or provide **Members** access to discounts on health care related goods or services. While **HMO** has arranged for access to these goods, services and/or third party provider discounts, the third party service providers are liable to the **Members** for the provision of such goods and/or services. **HMO** is not responsible for the provision of such goods and/or services nor is it liable for the failure of the provision of the same. Further, **HMO** is not liable to the **Members** for the negligent

provision of such goods and/or services by third party service providers. These discounts are subject to modification or discontinuance without notice.

## DEFINITIONS

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

- **Allowable Expense(s).** Any **Medically Necessary** health expense, part or all of which is covered under any of the plans covering the **Member** for whom claim is made. A health care service or expense including **Deductibles**, **Coinsurance** or **Copayments** that is covered in full or in part by any of the plans covering the **Member**, except as set forth below or where a statute requires a different definition. As described in the Coordination of Benefits Section, when **HMO** determines it pays its benefits after another plan or plans which also cover the **Member**, **HMO** pays 100% of the **Allowable Expense**. This means that an expense or service or a portion of an expense or service that is not covered by any of the plans is not an **Allowable Expense**. The following are examples of expenses or services that are not an **Allowable Expense**:

  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 patient'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 for private **Hospital** 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 the **Reasonable Charge,** any amount in excess of the lowest of the **Reasonable Charges** for a specified 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 lowest of the negotiated fees is not an **Allowable Expense**.

  4. The amount a benefit is reduced by the primary plan because a **Member** does not comply with the plan provisions is not an **Allowable Expense**. Examples of these provisions are second surgical opinions, pre-authorization requirements, and **Participating Provider** arrangements.

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

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

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

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

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

- **Copayment.** The specified dollar amount or percentage required to be paid by or on behalf of a **Member** in connection with benefits, if any, as set forth in the Schedule of Benefits. **Copayments** may be changed in accordance with the conditions set forth in the **Group Agreement**.

- **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, body piercing, rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of **Cosmetic Surgery**.

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

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

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

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

- **Deductible.** The first payments up to a specified dollar amount which a **Member** must make in the applicable calendar year for **Covered Benefits**.

- **Detoxification.** The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent

factors or alcohol in combination with drugs as determined by a licensed **Physician**, while keeping the physiological risk to the patient at a minimum.

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

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

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

- **Experimental or Investigational Procedures.** Services or supplies that are, as determined by **HMO**, experimental. A drug, device, procedure or treatment will be determined to be experimental if:

  1. there is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or

  2. required FDA approval has not been granted for marketing; or

  3. a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or

  4. the written protocol or protocol(s) used by the treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or

  5. it is not of proven benefit for the specific diagnosis or treatment of a **Member's** particular condition; or

  6. it is not in general use and is not generally recognized by the medical community as effective or appropriate for the specific diagnosis or treatment of a **Member's** particular condition; or

  7. it is provided or performed in special settings for research purposes.

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

- **Health Professionals.** A **Physician** or other professional who is properly licensed or certified under Title 18 of Washington Laws to provide medical care, and who provides **Medical Services** which are within the scope of the individual's license or certificate.

- **HMO.** Aetna U.S. Healthcare Inc. a Washington corporation licensed by the State of Washington Office of the Insurance Commissioner 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, coordinated and pre-authorized by **HMO**.

- **Hospice Care.** A program of care that is provided by a **Hospital**, **Skilled Nursing Facility**, hospice, a duly licensed **Hospice Care Agency** or **Hospice Facility**, licensed under RCW 70.126.010, 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.

- **Hospice Care Agency.** An agency or organization, licensed under RCW 70.126.010 which:

  1. has **Hospice Care** available 24 hours a day;

  2. meets all licensing or certification standards set forth by the jurisdiction where it is located;

  3. provides skilled nursing services; medical social services; psychological and dietary counseling; and bereavement counseling for the immediate family;

  4. provides or arranges for other services which will include services of a **Physician**; physical or occupational therapy; part-time home health aide services which mainly consist of caring for terminally ill persons; and inpatient care in a facility when needed for pain control and acute and chronic symptom management;

  5. has personnel which include at least one **Physician**, one R.N., one licensed or certified social worker employed by the Agency; and one pastoral or other counselor;

  6. establishes policies governing the provision of **Hospice Care**;

  7. assesses the patient's medical and social needs;

  8. develops a **Hospice Care** program to meet those needs;

  9. provides an ongoing quality assurance program. This includes reviews by **Physicians**, other than those who own or direct the Agency;

  10. permits all area medical personnel to utilize its services for their patients;

  11. keeps a medical record on each patient;

  12. utilizes volunteers trained in providing services for non-medical needs; and

  13. has a full time administrator.

- **Hospice Facility.** A facility, or distinct part of one, licensed under RCW 70.126.010 which:

  1. mainly provides inpatient **Hospice Care** to terminally ill individuals

  2. charges its patients;

  3. meets all licensing or certification standards set forth by the jurisdiction where it is located;

  4. keeps a medical record on each patient;

  5. provides an ongoing quality assurance program; this includes reviews by **Physicians** other than those who own or direct the facility;

  6. is run by a staff of **Physicians**; at least one such **Physician** must be on call at all times;

  7. provides, 24 hours a day, nursing services under the direction of an R.N.; and

8. has a full-time administrator.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- **Primary Care Provider (PCP).** A **Participating Physician,** or licensed and qualified ARNP or Physician's Assistant who supervises, coordinates and provides initial care and basic **Medical Services** (as a general or family care practitioner, or in some cases, specializing in internal medicine or pediatrics) 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 Office of the Insurance Commissioner.

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

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

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

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

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

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

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

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

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

- **Urgent Care. Covered Benefits** required in order to prevent serious deterioration of a **Member's** health that results from an unforeseen illness or injury 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's** return to the **Service Area**.

- **Woman's Health Care Specialist.** A **Provider** licensed under Washington RCW chapters 18.57 (MDs), 18.71 (DOs), 18.57A Physicians Assistants, 18.57B Physicians Assistants, 18.79 (ARNP's) specializing in obstetrics, gynecology, or midwifery or 18.50 licensed midwives.

**Aetna U.S. Healthcare Inc.**
**(Washington)**

**DOMESTIC PARTNER RIDER**

**Contract Holder Group Agreement** Effective Date: October 1, 2003

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. provides proof of cohabitation (e.g. driver's license or tax return);
ii. are both of the age of consent in their state of residence;
iii. are not related by blood in any manner that would bar marriage in their state of residence;
iv. have a close, committed and monogamous personal relationship;
v. have been sharing the same household on a continuous basis for at least [6-24]6 months;
vi. have registered as domestic partners where such registration is available;
vii. is not married to, or separated from, another individual;
viii. have not been registered as a member of another domestic partnership within the last [6-24]6 months; [and]
ix. demonstrates financial interdependence by submission of proof of [1-6]3 [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.

**HCSC** may request documentation of any of the foregoing prior to commencing coverage for a domestic partner.

**HMO** may request documentation of any of the foregoing prior to commencing coverage for a domestic partner.

**AETNA U.S. HEALTHCARE INC.**
**(WASHINGTON)**

**AMENDMENT**

**Group Agreement** Effective Date: October 1, 2003

**SEATTLE SD/1 CHILD ONLY TIERS**
**Contract Holder Number: 056659**
**Contract Holder Locations: 001**
**Contract Holder Service Areas: WA01**

The **Group Agreement** for the **Contract Holder** mentioned above has been amended. The following is added to and made a part of the **Group Agreement**, and is subject to all the terms and conditions stated in the **Group Agreement** and those stated in this Amendment. This Amendment is effective on the date specified above.

The Certificate of Coverage is amended as follows:

The following benefit is added to the Covered Benefits Section, Additional Benefits:

- Limited General Anesthesia for Dental Procedures

  General anesthesia and associated facility charges for dental procedures rendered in a hospital or surgery center are covered when:

  1. pre-authorized by **HMO**,

  2. the clinical status or underlying medical condition of the Member requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital or surgery center, and

  3. the Member for whom the treatment is proposed

     a. is under seven years of age, or
     b. is developmentally disabled, regardless of age, or
     c. has a health condition which makes the general anesthesia **Medically Necessary**, regardless of age.

  Coverage does not include charges for the dental procedure itself, including, but not limited to, the professional fees of the dentist. Coverage is subject to the applicable Copayments for applicable services, if any, listed in the Schedule of Benefits.

  Coverage is provided for medically necessary general anesthesia services in a dental office which are provided in conjunction with any covered, **Medically Necessary** dental procedure if the **Member** is under the age of 7 or physically or developmentally disabled.

  Coverage does not include charges for the dental procedure itself, including, but not limited to, the professional fees of the dentist. Coverage is subject to the applicable Copayments for applicable services, if any, listed in the Schedule of Benefits.

**MISCELLANEOUS PROVISIONS**

In the event of any conflict between this Amendment and the **Group Agreement**, this Amendment shall prevail. This Amendment shall not vary, alter, waive, or extend any of the terms, conditions, provisions, or limitations of the **Group Agreement**, other than as stated above.

**AETNA U.S. HEALTHCARE INC.**
**(WASHINGTON)**

# CERTIFICATE OF COVERAGE AMENDMENT

**Contract Holder Group Agreement** Effective Date: October 1, 2003

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

- **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 medical cause of **Infertility**.

**AETNA HEALTH INC.**
**(WASHINGTON)**

**AMENDMENT TO THE CERTIFICATE OF COVERAGE**

**Group Agreement** Effective Date: October 1, 2003

Section D. Conversion Privilege of the Continuation and Conversion section of the **HMO Certificate of Coverage** has been amended to include paragraph 3. under the "Eligibility" section.

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

**AETNA U.S. HEALTHCARE INC.**
**(WASHINGTON)**

## AMENDMENT TO THE CERTIFICATE OF COVERAGE

**Contract Holder Group Agreement** Effective Date: October 1, 2003

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

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

2. All references to the "Grievance Procedure" sections in the **Certificate** is hereby deleted and replaced by the following:

   "Claim Procedures/Complaints and Appeals/External Independent Medical Review"

3. The "Grievance Procedure" Section(s) of the **Certificate** is hereby deleted and replaced by the following:

### CLAIM PROCEDURES/COMPLAINTS AND APPEALS/EXTERNAL INDEPENDENT MEDICAL REVIEW

### 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 and pre-service 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 are E**xperimental 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; or
- 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 **Complaints** and **Appeals** section of this **Certificate** for more information about **Appeals**.

| **HMO Timeframe for Notification of an Adverse Benefit Determination** | |
|---|---|
| **Type of Claim** | **HMO**<br>**Response Time from Receipt of Claim**<br>**Response Time from Receipt of Claim** |
| **Urgent Care Claim**. A claim for medical care or treatment where delay could seriously jeopardize the life or health of the **Member,** the ability of the **Member** to regain maximum function; or subject the **Member** to severe pain that cannot be adequately managed without the requested care or treatment. | As soon as possible but not later than 72 hours.<br><br>Emergency Care: within 30 minutes of telephone request for preauthorization for emergency medical services not to include inpatient admission. |
| **Pre-Service Claim**. A claim for a benefit that requires pre-authorization of the benefit in advance of obtaining medical care. | 2 business days (within receipt of complete information);<br><br>20 days for experimental and investigational services determination. No preauthorization requirement if a **Member** or the **Member's Covered Dependents** receive Mental Health care and treatment from a state hospital if the **Member** is involuntarily committed. |
| **Concurrent Care Claim Extension.** A request to extend a course of treatment previously pre-authorized by **HMO**. | 2 business days;<br><br>20 days for experimental and investigational services determination. No preauthorization requirement if a **Member** or the **Member's Covered Dependents** receive Mental Health care and treatment from a state hospital if the **Member** is involuntarily committed. |
| **Concurrent Care Claim Reduction or Termination.** Decision to reduce or terminate a course of treatment previously pre-authorized by **HMO**. | With enough advance notice to allow the **Member** to **Appeal.** |
| **Post-Service Claim**. A claim for a benefit that is not a pre-service claim. | Within 30 calendar days of receipt of clean claims and 60 days of receipt of all claims;<br>Within 20 business days of receipt of a claim for experimental/investigational services;<br>No retrospective denial for services preauthorized when services were rendered. |

## 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.

If the state of Washington requirements are more beneficial to the **Member**, the state requirements govern.

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

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

A. **Complaints**.

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

B. **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 180 calendar days from the date of the notice.

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

The **HMO** provides for one level of **Appeal** of the adverse benefit determination. The **Member** must complete that level of **HMO** review before bringing a lawsuit against the **HMO**. If the **Member** decides to **Appeal**, the request must be made in writing within 60 calendar days from the date of the notice. The following chart summarizes some information about how the **Appeals** are handled for different types of claims.

| **HMO Timeframe for Responding to an Adverse Benefit Determination Appeal** | |
|---|---|
| **Type of Claim** | **Level One Appeal HMO Response Time from Receipt of Appeal** |

| | |
|---|---|
| **Urgent Care Claim**. A claim for medical care or treatment where delay could seriously jeopardize the life or health of the **Member,** the ability of the **Member** to regain maximum function; or subject the **Member** to severe pain that cannot be adequately managed without the requested care or treatment. | Within 72 hours<br><br>Review provided by **HMO** personnel not involved in making the adverse benefit determination. |
| **Pre-Service Claim**. A claim for a benefit that requires approval of the benefit in advance of obtaining medical care. | 14 calendar days from receipt of the appeal.<br><br>Review provided by **HMO** personnel not involved in making the adverse benefit determination. |
| **Concurrent Care Claim Extension.** A request to extend or a decision to reduce a previously approved course of treatment. | Treated like an urgent care claim or a pre-service claim depending on the circumstances |
| **Post-Service Claim**. Any claim for a benefit that is not a pre-service claim. | 14 calendar days from receipt of the appeal.<br><br>Review provided by **HMO** personnel not involved in making the adverse benefit determination. |

C. **External Independent Medical Review**

1. The **Member** may request review by a certified independent review organization of an adverse determination if:

   a. the **Member** has completed the **Complaints** and **Appeals** hearing process and the adverse determination has been upheld, or

   b. the **HMO** has exceeded the timelines for **Complaints** and **Appeals** hearings set forth above without good cause and without reaching a decision.

2. Not later than the third business day after the date the **HMO** receives a request for an independent medical review, **HMO** will provide to the Independent Medical Review Organization designated by the Office of the Insurance Commissioner:

   a. the medical records of the **Member** that are relevant to the review;

   b. documents used by **HMO** in making the determination to be reviewed;

   c. a list of each **Physician** or **Health Care Professional** who has provided care to the **Member** and who may have medical records relevant to the **Appeal**;

   d. the treating **Provider's** recommendations; and

   e. the terms and conditions of coverage of the **Member's** plan.

3. **HMO** will make available to the **Member** and/or the **Member's** treating **Provider** copies of all materials provided to the independent review organization. The **Member** and the **Member's** treating **Provider** will make available to **HMO** any information that they provided to the independent review organization in support of their appeal.

4. If the independent medical review request involves services which the **Member** is currently receiving (for example, the **Member** is currently hospitalized and **HMO** has determined that coverage for continued inpatient care is not **Medically Necessary**) **HMO** will continue to provide

coverage for the services until the independent review organization makes their decision. If the independent review organization decision upholds the **HMO's** determination, the **Member** will be responsible for the cost of the continued health care services.

5. If the independent review organization's determination overturns the **HMO's** decision the **HMO** will promptly comply with the final determination.

6. The **Member** is not responsible for any portion of the independent review organization's charges.

D. **Member's Final Process.**

If the **Member** is not satisfied with the final decision made on their **Complaints** and **Appeals** in this **Claim Procedures/Complaints and Appeals/External Independent Medical Review** section of the **Certificate**, the **Member** may pursue the establishing of any litigation 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** resolution process of any **Complaints** and **Appeals**.

E. **Record Retention.**

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

F. **Fees and Costs.**

Nothing herein shall be construed to require **HMO** to pay counsel fees or any other fees or costs incurred by a **Member** in pursuing a **Complaint** or **Appeal**, except that the **Member** shall not be responsible for any costs arising from voluntary mediation or Independent Medical Review.

**Aetna U.S. Healthcare Inc.**
**(Washington)**

**ENROLLMENT ENDORSEMENT**

**Contract Holder Group Agreement** Effective Date: October 1, 2003

The **Aetna U.S. Healthcare Inc. Certificate** is hereby amended as follows:

**ELIGIBILITY AND ENROLLMENT**

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

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

"Life Events" are limited to:

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

**Aetna U.S. Healthcare Inc.**

**PRESCRIPTION PLAN RIDER**

**Group Agreement** Effective Date: October 1, 2003

Aetna U.S. Healthcare Inc. (**"HMO"**) and **Contract Holder** agree to offer to **Members** the **HMO** Prescription Plan, 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**.

- **Drug Formulary** - A listing 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. An updated copy of the **Drug Formulary** shall be available at any time upon request by the **Member**.

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

- **Generic Prescription Drug(s)** - Prescription drugs and insulin, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient.

- **Maintenance Drugs** - A listing of prescription drugs or medications established by **HMO** or an affiliate which is subject to periodic review and modification by **HMO** or an affiliate. The list consists of prescription drugs or medications that are taken for extended periods of time, and which do not vary frequently in terms of dosage (such as high blood pressure medication).
- **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**.

- **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**.

- **Therapeutic Interchange Program.** The **Therapeutic Interchange Program** is an educational program through which **Members** and **Physicians** are informed of available drug alternatives where said prescription drugs products are considered therapeutically equivalent and clinically efficacious. All substitutions are subject to the prescribing **Physician's** review and approval.

## COVERED BENEFITS

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

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

**Medically Necessary** outpatient prescription drugs and insulin are covered when prescribed by a **Provider** licensed to prescribe federal legend prescription drugs or medicines subject to the terms, **HMO** policies, limitations and exclusions described in the **Certificate** and this rider. 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 prior 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 Pharmacy**. Not all **Brand Name Prescription Drugs** are covered.

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 **Precertification, Step Therapy, Therapeutic Interchange Programs** 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 **Precertification Program**, **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 and **Member** does not have access to a **Participating Retail Pharmacy** 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 **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 cost differentials as applicable. Coverage for items obtained from **Non-Participating Pharmacies** is limited to items obtained in connection with covered **Emergency** and **Out-of-Area Urgent Care** services.

When a **Member** obtains an **Emergency** or **Urgent Care** prescription at any **Participating Retail Pharmacy,** including out of area **Participating Retail Pharmacies**, **Member** will pay to the **Participating Retail Pharmacy** the **Copayment(s)**, plus the brand name cost differentials where applicable and as described below. **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 it's sole discretion.

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 dispensed by a **Participating Mail Order Pharmacy** in quantities that are less than a 30 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 **Participating Physician's** order only at a **Participating Retail** or **Mail Order Pharmacy,** the **Member** must pay a separate **Copayment** for each item.

  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.

G. **Copayments:**

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

The **Member** is responsible for a **Copayment** in the amount of $10 per prescription or refill
for a **GenericFormulary Prescription Drug**.

The **Member** is responsible for a **Copayment** in the amount of $20 per prescription or refill for a **Brand Name Formulary Prescription Drug**.

The **Member** is responsible for a **Copayment** in the amount of $35 per prescription or refill for a **Non-Formulary Prescription Drug**.

H. The Formulary Guide contains drugs that have been reviewed by **HMO** Pharmacy and Therapeutics (P&T) Committee. The P&T Committee reviews the entire Formulary Guide at least

annually. The P&T Committee reviews information from a variety of sources, including FDA guidelines, manufacturer labeling, peer review journals and other independently developed materials. Using this information, the P&T Committee periodically evaluates the therapeutic effectiveness of prescription medications and places them into one of three categories:

| | |
|---|---|
| Category I | The drug represents an important therapeutic advance. |
| Category II | The drug is therapeutically similar to other available products. |
| Category III | The drug has significant disadvantages in safety or efficacy when compared to other similar products. |

The drugs in Category I are always included on the **HMO** Formulary, and the drugs placed in Category III are always excluded from the Formulary. For therapeutically similar drugs in Category II, **HMO** selects drugs for the Formulary based on the recommendations of the P&T Committee, the cost effectiveness of the medication, any manufacturer volume discount arrangements under which **HMO** receives financial consideration, and other factors.

Until a new FDA-approved drug has been reviewed by the Aetna Health Inc. P&T Committee and a formulary determination made, it may not be listed on the formulary. Some benefit plans exclude coverage of new drugs until they have been reviewed, while other benefit plans allow for coverage of new drugs. Under those plans that allow such coverage, the non-formulary copayment will apply.

## EXCLUSIONS AND LIMITATIONS

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

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 and dosage form, 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 except diabetic needles and syringes.

6. Any medication which is consumed or administered at the place where it is dispensed, or while a patient 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 (i.e., 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.

13. Test agents and devices except diabetic test agents.

14. Injectable drugs used for the purpose of treating **Infertility**, unless otherwise covered by **HMO**.

15. Injectables 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. Sildenafil citrate, phentolamine, apomorphine and alprostadil in oral, injectable and topical (including but not limited to gels, creams, ointments and patches) forms, 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.

20 Performance, athletic performance or lifestyle enhancement drugs and supplies.

21. 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.

22. 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.

23. Medication packaged in unit dose form. (Except those products approved for payment by **HMO**).

24. Prophylactic drugs for travel.

25. Drugs recently approved by the FDA, but which have not yet been reviewed by the Aetna Health Inc's Pharmacy Management Department and Therapeutics Committee.

26. Drugs for the convenience of **Member**s or for preventive purposes unless covered by **HMO** in its sole discretion.

27. Drugs listed on the **Formulary Exclusions List** unless otherwise covered through a medical exception as described in this rider or covered under of this rider.

28. Nutritional supplements.

29. Smoking cessation aids or drugs.

30. Growth hormones.

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 designated **Mail Order Pharmacy**. 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** or a non-**Participating Retail Pharmacy** in **Non-Emergency**, **Non-Urgent Care** situations. **HMO** retains the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to the Grievance Procedure section of the **Certificate**.

3. **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** except in an **Emergency** or **Urgent Care** situation and **Member** will be responsible for the entire cost of the prescription.

4. The Continuation and Conversion section of the **Certificate** is hereby amended to include the following provision: The conversion privilege does not apply to the **HMO** Prescription Plan.

5. **HMO** is not responsible for the cost of any prescription drug for which the actual charge to the **Member** is less than the required **Copayment** or for any drug for which no charge is made to the recipient.

6. **Member** will be charged the **Non-Formulary Prescription Drugs Copayment** for prescription drugs covered on an exception basis.

*Washington State law requires that the following notice be provided to covered persons.*

*YOUR RIGHT TO SAFE AND EFFECTIVE PHARMACY SERVICES*

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan and what coverage limitations are in your contract. If you would like more information about the drug coverage policies under this plan, or if you have a question or concern about your pharmacy benefit, please contact Aetna Health Inc. at the number listed on your identification card.

If you would like to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract, you may contact the Washington State Office of Insurance Commissioner at 1-800-562-6900. If you have a concern about the pharmacists or pharmacies serving you, please call the State Department of Health at 360-236-4825.

**Aetna U.S. Healthcare Inc.**
**(Washington)**

## SCHEDULE OF BENEFITS

**CITIZEN PLAN**
**SEATTLE SCHOOL DISTRICT**
**Contract Holder Group Agreement Effective Date: October 1, 2003**
**Contract Holder Number: 056659**
**Contract Holder Locations: 001**
**Contract Holder Service Areas: WA01**

| | |
|---|---|
| **Maximum Out-of-Pocket Copayment Limit** (Includes the **Deductible** Amount) | **$1,500 per Member per Contract Year**<br>**$3,000 per family per Contract Year** |

## OUTPATIENT BENEFITS

| **Benefit** | **Copayment** |
|---|---|
| **Primary Care Physician Office Visit** | |
| During Office Hours | **$15 per visit** |
| Non-Office Hours and Home Visits | **$20 per visit** |
| Well Child Care and Immunizations | **$15 per visit** |
| **Specialist Physician Services** | |
| When Provided during an office visit | **$20 per visit** |
| When provided other than during an office visit | **$20 per visit** |
| **Outpatient Rehabilitation Benefits** | |
| Treatment over a 60-day consecutive period per incident of illness or injury beginning with the first day of treatment | **$20 per visit** |
| **Neurodevelopmental Therapy** | |
| **(through age 6)**<br>**60 visits per calendar year. Each standard length visit with a single provider type is considered one visit.** | **$20 per visit** |
| **First OB Visit** | **$20** |
| **Routine Gynecological Exam(s)** | |
| 1 visit(s) per 365 consecutive day period | **$20 per visit** |
| **Hospital Outpatient Department Visit** | **$20 per visit** |
| **Diagnostic X-Ray Testing** | **$20 per visit** |
| Hospital Outpatient Facility | |

## OUTPATIENT BENEFITS
## (continued)

| | |
|---|---|
| Facility other than Hospital Outpatient | **$20 per visit** |
| **Diagnostic Laboratory Testing** | **$20 per visit** |
| Hospital Outpatient Facility | |
| Facility other than Hospital Outpatient | **$20 per visit** |
| **Outpatient Emergency Services** | **$50 per visit** |
| Hospital Emergency Room, Urgent Care Facility, or Outpatient Department | |
| **Ambulance** | **$0 per trip** |
| **Outpatient Mental Health Visits** | |
| **20 visits per calendar year** | **$25 per visit**<br>**Visits 1 - 20: $25** |
| **Outpatient Substance Abuse Visits** | |
| Detoxification | **$15 per visit** |
| **Rehabilitation:** | |
| Combined inpatient/outpatient maximum of **$11,285** per 24 consecutive months | **0% (of the contracted rate) per visit** |
| **Outpatient Surgery** | **$50 per visit** |
| **Outpatient Home Health Visits** | |
| unlimited visits per calendar year | **$0 per visit** |
| **Outpatient Hospice Visits** | **$0 per visit** |
| **Injectable Medications** | **$15 per prescription** |

## INPATIENT BENEFITS

| **Benefit** | **Copayment** |
|---|---|
| **Acute Care** | **$100 per admission** |
| **Mental Health** | |
| Maximum of **30** days per calendar year | **$100 per admission** |
| **Substance Abuse** | |
| Detoxification | **$100 per admission** |
| **Substance Abuse** | |
| Rehabilitation: Combined inpatient/outpatient maximum of **$11, 285** per 24 consecutive months. | **$100 per admission** |
| **Maternity** | **$100 per admission** |

**INPATIENT BENEFITS**
**(continued)**

| | |
|---|---|
| **Skilled Nursing Facility**<br>Maximum of unlimited days per | **$100 per admission (waived if a Member is transferred from a Hospital to a Skilled Nursing Facility)** |
| **Hospice** | **$100 per admission (waived if a Member is transferred from a Hospital to a Hospice Care facility)** |

## ADDITIONAL BENEFITS

| **Benefit** | **Non-Participating Provider or Participating Provider Self-Referral Copayment/Coinsurance** |
|---|---|
| **Routine Eye Exam as per schedule in certificate** | **$20 per visit** |
| **Subluxation Benefits**<br>20 visits per calendar year | **$20 per visit** |
| **Durable Medical Equipment Benefits:** | |
| **Copayment** | **$0 per item** |
| **Annual Out-of-Pocket Maximum**<br>Counts toward Maximum Out-of-Pocket Copayment Limit | **unlimited per Member, per calendar year** |
| **Maximum Annual Benefit** | **unlimited per Member, per calendar year** |

**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 first of the month following the date of hire.

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

i. under 19 years of age; or

ii. under 23 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: 19, or if a student, 23.

**Termination of Coverage:**

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

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