

DISCLOSURE BROCHURE
for
NEVADA INDIVIDUAL STANDARD PLAN

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This disclosure brochure is to be made available to each individual prior to purchase of this plan. The disclosure brochure consists of a sample Certificate of Coverage and Schedule of Benefits. This brochure is only a summary of the terms and conditions of the plan. The Group Agreement, Certificate of Coverage and Schedule of Benefits should be consulted to determine the governing contractual provisions of the Plan.

Under the Aetna plan, **usual and customary** is referred to as **reasonable charge**, which is defined in the attached sample Certificate of Coverage on page 31.

The **Exclusions and Limitations** Section of the Certificate of Coverage begins on page 13.

Individuals have the right to renew this plan annually **except** under the following circumstances:

1. Aetna Health, Inc. discontinues transacting insurance in Nevada, or in the geographic area where the individual is located, in accordance with all statutory requirements;
2. The individual fails to pay the premiums or contributions required by the terms of this plan;
3. The individual misrepresents any information regarding the members covered under this plan or other information regarding eligibility for coverage under this plan;
4. The individual commits a fraudulent act to obtain or maintain coverage under the plan.

Additional information regarding termination of coverage may be found in the Certificate of Coverage starting on page 15.

**DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR
NEVADA INDIVIDUAL CONVERSION STANDARD PLAN**

**AETNA HEALTH, INC.
(NEVADA)**

INDIVIDUAL CONVERSION CERTIFICATE OF COVERAGE

This is an Individual Conversion Certificate of Coverage (hereinafter referred to as "**Certificate**") between Aetna Health, Inc., hereinafter referred to as **HMO**, and the **Contract Holder**. This **Certificate** determines the terms and conditions of coverage. Provisions of this **Certificate** include the Enrollment Form, Schedule of Benefits, and any amendments or endorsements. Amendments or endorsements may be delivered with the **Certificate** or added thereafter.

If any provision of this **Certificate** is deemed to be invalid or illegal, such provision shall be fully severable and the remaining provisions of this **Certificate** shall continue in full force and effect. In consideration of the **Premium** payments made by or on behalf of the **Contract Holder**, **HMO** shall provide coverage for those services described in this **Certificate** subject to the terms and conditions set forth in this **Certificate**.

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 this **Certificate**.

This **Certificate** describes covered health care benefits. Coverage for services or supplies is provided only if it is furnished while an individual is a **Member**. This means that coverage is provided only for health care services furnished while this coverage is in force. Except as shown in the Continuation and Conversion section of this

Certificate, coverage is not provided for any services received before coverage starts or after coverage ends.

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

This Certificate is not in lieu of insurance for Worker's Compensation. This Certificate is governed by applicable federal law and the laws of the State of Nevada.

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. MEMBERS WITH QUESTIONS REGARDING OF THE TERMS OR CONDITIONS DESCRIBED HEREIN MAY CALL HMO AT THE 800 NUMBER LISTED ON THEIR ID CARD.

THE NEVADA DIVISION OF INSURANCE PROVIDES A TOLL FREE TELEPHONE NUMBER WHICH NEVADA CONSUMERS MAY USE FOR INQUIRIES AND COMPLAINTS REGARDING HEALTH PLANS.
---1-888-872-3234 -- HOURS OF OPERATION --- 8AM TO 5PM WEEKDAYS ---

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

NO SERVICES ARE COVERED UNDER THIS CERTIFICATE IN THE ABSENCE OF PAYMENT OF CURRENT PREMIUMS SUBJECT TO THE 31-DAY GRACE PERIOD AND THE PREMIUMS SECTION OF THIS CERTIFICATE.

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

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

**DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR
NEVADA INDIVIDUAL CONVERSION STANDARD PLAN**

TABLE OF CONTENTS

Section	Page
HMO Procedure	1
Eligibility and Enrollment	2
Covered Benefits	4
Exclusions and Limitations	13
Termination of Coverage	15
Continuation	17
Grievance Procedure	18
Coordination of Benefits	21
Responsibility of Members	23
General Provisions	24
Premiums	27
Definitions	28

SAMPLE

DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR NEVADA INDIVIDUAL CONVERSION STANDARD PLAN

HMO PROCEDURE

A. Selecting a Participating Primary Care Physician.

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

B. The Primary Care Physician.

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

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

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**.

D. Changing a PCP.

A **Member** may change the **PCP** at any time by calling the Member Services 800 telephone number listed on the **Member's** identification card or by written or electronic submission of the **HMO's** change form. A **Member** may contact **HMO** to request a change form or for assistance in completing that form. The change will become effective upon **HMO's** receipt and approval of the request.

E. Ongoing Reviews.

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

F. Authorization.

Certain services and supplies under this **Certificate** may require authorization by **HMO** to determine if they are **Covered Benefits** under this **Certificate**. Those services and supplies requiring **HMO** authorization are indicated in this **Certificate**.

DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR NEVADA INDIVIDUAL CONVERSION STANDARD PLAN

ELIGIBILITY AND ENROLLMENT

A. Eligibility.

1. To be eligible to enroll as a **Subscriber**, an individual must:
 - a. live or work in the **Service Area**; and
 - b. be a former **Subscriber** in an **HMO** plan, whose coverage terminated under a Group Agreement and to whom the conversion privilege is available thereunder.
2. To be eligible to enroll as a **Covered Dependent** the dependent must be:
 - a. the legal spouse of a **Subscriber**; or
 - b. a dependent unmarried child (including natural, foster, step, legally adopted children, proposed adoptive children, and a child under court order) who meets the eligibility requirements described on the Schedule of Benefits.
3. A **Member** who resides outside the **Service Area** is required to choose a **PCP** and return to the **Service Area** for **Covered Benefits**. **Members** shall be covered for **Emergency Services** and **Urgent Care** services only when obtained outside the **Service Area**.

B. Enrollment.

Unless otherwise noted, an eligible individual and any eligible dependents may enroll in **HMO** regardless of health status, age, or requirements for health services within 45 days from the date of termination of eligibility as a **Subscriber** under a Group Agreement.

1. Newly Eligible Individuals and Eligible Dependents.

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

2. Enrollment of Newly Eligible Dependents.

- a. Newborn Children.

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

The coverage for newly born, adopted children, and children placed for adoption 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.

**DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR
NEVADA INDIVIDUAL CONVERSION STANDARD PLAN**

b. Adopted Children.

A legally adopted child or a child for whom a **Subscriber** is a court appointed legal guardian, and who meets the definition of a **Covered Dependent**, will be treated as a dependent from the date of adoption or upon the date the child was placed for adoption with the **Subscriber**. "Placed for adoption" means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The placement must take effect on or after the date a **Subscriber's** coverage becomes effective, and the **Subscriber** must make a written request for coverage within 31 days of the date the child is adopted or placed with the **Subscriber** for adoption.

The initial coverage will not be affected by any provision in this **Certificate** which:

- i. requires evidence of good health acceptable to **HMO** for coverage to become effective;
- ii. delays coverage due to a confinement; or
- iii. limits coverage as to a preexisting condition.

4. Special Rules Which Apply to Children.

a. Qualified Medical Support Order.

Coverage is available for a dependent child not residing with a **Subscriber** and who

resides outside the **Service Area**, if there is a qualified medical child support order requiring the **Subscriber** to provide dependent health coverage for a non-resident child, and is issued on or after the date the **Subscriber's** coverage becomes effective. The child must meet the definition of a **Covered Dependent**, and the **Subscriber** must make a written request for coverage within 31 days of the court order.

The initial coverage will not be affected by any provision in this **Certificate** which:

- i. requires evidence of good health acceptable to **HMO** for coverage to become effective;
- ii. delays coverage due to a confinement; or
- iii. limits coverage as to a preexisting condition.

b. Handicapped Children.

Coverage is available for a child who is chiefly dependent upon the **Subscriber** for support and maintenance, and who is 19 years of age or older but incapable of self-support due to mental or physical incapacity. The incapacity must have commenced prior to the age the dependent lost eligibility. In order to continue coverage for a handicapped child, the **Subscriber** must provide evidence of the child's incapacity and dependency to **HMO** within 31 days of the date the child's coverage would otherwise terminate. Proof of continued incapacity, including a medical examination, must be submitted to **HMO** as requested, but not more frequently than annually beginning after the two 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.

DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR NEVADA INDIVIDUAL CONVERSION STANDARD PLAN

5. Notification of Change in Status.

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

An eligible individual and any eligible dependents may be enrolled if the eligible individual's spouse was covered under another health benefit plan and lost coverage because of termination of coverage, for reasons other than gross misconduct, within 31 days of the loss of coverage even though it is not during the **Open Enrollment Period**. **HMO's** completed change form must be submitted to the **Contract Holder** within 31 days of the event causing the change in status.

C. Effective Date of Coverage.

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

COVERED BENEFITS

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

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

- be care or appropriate necessary and required services, according to generally accepted principles of medical practice for the 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**;
- 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;

DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR NEVADA INDIVIDUAL CONVERSION STANDARD PLAN

- 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 800 telephone number listed on the **Member's** identification card.

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

EXCEPT FOR DIRECT ACCESS SPECIALIST BENEFITS OR IN A MEDICAL EMERGENCY OR URGENT CARE SITUATION AS DESCRIBED IN THIS S CERTIFICATE, THE FOLLOWING

BENEFITS MUST BE ACCESSED THROUGH THE PCP'S OFFICE THAT IS SHOWN ON THE MEMBER'S IDENTIFICATION CARD, OR ELSEWHERE UPON PRIOR REFERRAL ISSUED BY THE MEMBER'S PCP.

A. Primary Care Physician Benefits.

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

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

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

**DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR
NEVADA INDIVIDUAL CONVERSION STANDARD PLAN**

- 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.

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

1. diagnostic, laboratory, and x-ray services.
2. mammograms, by a **Participating Provider**. The **Member** is required to obtain a **Referral** from her **PCP** or gynecologist, or obtain prior authorization from **HMO** to a **Participating Provider**, prior to receiving this benefit.

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

- One baseline mammogram between the ages of 35 and 40.
 - age 40 and older, one routine mammography at age forty and every twelve month period thereafter from the initial exam;
 - or when **Medically Necessary**.
3. annual cytologic screening test for women 18 years of age or older.

C. Specialist Physician Benefits.

Covered Benefits include outpatient and inpatient services.

D. Direct Access Specialist Benefits.

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

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

**DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR
NEVADA INDIVIDUAL CONVERSION STANDARD PLAN**

E. Maternity Care and Related Newborn Care.

- 1) Outpatient and inpatient pre-natal and postpartum care and obstetrical services provided by **Participating Providers** are a **Covered Benefit**. To be covered for these benefits, the **Member** must choose a **Participating** obstetrician from **HMO's** list of **Participating Providers** and inform **HMO** by calling the Member Services 800 telephone number listed on the **Member's** identification card, prior to receiving services. The **Participating Provider** is responsible for obtaining prior authorization for all obstetrical care from **HMO** after the first prenatal visit.

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

- 2) Complications of Pregnancy - **Member** is covered for complications of pregnancy, including any condition which requires **Hospital** confinement for **Medically Necessary** treatment and:
 - a) If the pregnancy is not terminated, if caused by an injury or sickness not directly related to the pregnancy or by acute nephritis, nephrosis, cardiac decompensation, missed abortion or similarly medically diagnosed condition; or,
 - b) If the pregnancy is terminated, results in nonelective cesarean section, ectopic pregnancy or spontaneous termination.

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 preauthorization by **HMO**. In the event that the **Member** elects to remain in the **Hospital** or **Skilled Nursing Facility** after the date that the **Participating Provider** and/or the **HMO** Medical Director has determined and advised the **Member** that the **Member** no longer meets the criteria for continued inpatient confinement, the **Member** shall be fully responsible for direct payment to the **Hospital** or **Skilled Nursing Facility** for such additional **Hospital, Skilled Nursing Facility, Physician** and other **Provider** services, and **HMO** shall not be financially responsible for such additional services.

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

1. a minimum of 48 hours of inpatient care in a **Participating Hospital** following a vaginal delivery;
2. a minimum of 96 hours of inpatient care in a **Participating Hospital** following a cesarean section; or
3. a shorter **Hospital** stay, if requested by a mother, and if determined to be medically appropriate by the **Participating Providers** in consultation with the mother.

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

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

DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR NEVADA INDIVIDUAL CONVERSION STANDARD PLAN

G. Transplants.

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

H. Outpatient Surgery Benefits.

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

Reconstructive surgery following a mastectomy. The **Member** is responsible for a **copayment** in the amount shown on the Schedule of Benefits, if any.

Emergency Care/Urgent Care Benefits.

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

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

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

2. The **Member** will be covered for **Urgent Care** services obtained from a licensed **Physician** or facility outside of the **Service Area** if:
 - a. the service is a **Covered Benefit**;
 - b. 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.

DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR NEVADA INDIVIDUAL CONVERSION STANDARD PLAN

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

J. Rehabilitation Benefits.

1. Inpatient and Outpatient Rehabilitation Benefits.

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

- a. Cardiac rehabilitation benefits are available as part of a **Member's** inpatient **Hospital** stay. A limited course of outpatient cardiac rehabilitation is covered when **Medically Necessary** following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- b. Pulmonary rehabilitation benefits are available as part of a **Member's** inpatient **Hospital** stay. A limited course of outpatient pulmonary rehabilitation is covered when **Medically Necessary** for the treatment of reversible pulmonary disease states.

2. Outpatient Rehabilitation Benefits.

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

- a. Cognitive therapy associated with physical rehabilitation is covered for non-chronic conditions and acute illnesses and injuries as part of a treatment plan coordinated with **HMO**.
- b. Physical therapy is covered for non-chronic conditions and acute illnesses and injuries.
- c. Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute illnesses.
- d. Speech therapy is covered for non-chronic conditions and acute illnesses and injuries. Services rendered for the treatment of delays in speech development, unless resulting from disease, injury, or congenital defects, are not covered.

K. Home Health Benefits.

The following services are covered when rendered by a **Participating** home health care agency. Preauthorization must be obtained from the **Member's** attending **Participating Physician**. **HMO** shall not be required to provide home health benefits when **HMO** determines the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide appropriate care. Coverage is subject to the maximum number of visits, if any, shown on the Schedule of Benefits.

1. Skilled nursing services for a **Homebound Member**. Treatment must be provided by or supervised by a registered nurse.
2. Services of a home health aide. These services are covered only when the purpose of the treatment is **Skilled Care**.

DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR NEVADA INDIVIDUAL CONVERSION STANDARD PLAN

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**.

L. Hospice Benefits.

Hospice Care services for a terminally ill **Member** are covered when preauthorized by **HMO**. Services may include home and **Hospital** visits by nurses and social workers; pain management and symptom control; instruction and supervision of a family **Member**; inpatient care; counseling and emotional support; and other home health benefits listed above.

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

M. Prosthetic Appliances.

The **Member's** initial provision of a prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease or injury or congenital defects is covered, when such device is prescribed by a **Participating Provider** and authorized in advance by **HMO**, including at least 2 breast prostheses subsequent to a mastectomy. 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.

N. Injectable Medications.

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

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

O. Temporomandibular Joint Syndrome Services.

Oral Surgery, limited to bony impactions of teeth, bone fractures, removal of tumors and orthodontogenic cysts or other pre approved surgical procedures. Coverage for the treatment for temporomandibular joint dysfunction shall include pre-authorized **Medically Necessary** procedures. **Medically Necessary** excludes dental procedures including, but not limited to, the extraction of teeth and the application of orthodontic devices and splints.

DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR NEVADA INDIVIDUAL CONVERSION STANDARD PLAN

P. Enteral Formulas

1. Enteral formulas for use at home that are prescribed or ordered by a **Participating Provider** as medically necessary are covered for the treatment of inherited metabolic diseases characterized by deficient metabolism, or malabsorption originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate or fat.
2. Coverage will be provided for at least \$2,500 per year for **Special Food Products** which are prescribed or ordered by a **Participating Provider** as medically necessary for the treatment of a **Member** described in section 1 above.

“**Inherited Metabolic Disease**” means a disease caused by an inherited abnormality of the body chemistry of a person.

“**Special Food Product**” means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a **Participating Provider** for the dietary treatment of an inherited metabolic disease. The term does not include a food that is naturally low in protein.

Q. Diabetes.

The management and treatment of Diabetes (type I, type II and gestational) is covered, including coverage for the self-management of Diabetes.

Coverage for the management and treatment of Diabetes includes coverage for medication, equipment, supplies and appliances that are **Medically Necessary** for the treatment of Diabetes.

Coverage, without limitation, for the self-management of Diabetes, includes :

1. Training and education provided to the **Member** after the original diagnosis, including counseling in nutrition and the proper use of equipment and supplies for the treatment of Diabetes;
2. Training and education as a result of a subsequent diagnosis that indicates a significant change in the symptoms or condition of the **Member** and which requires modification of the program of selfmanagement; and
3. Training and education due to the development of new techniques and treatment for Diabetes.

R. 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 the **HMO** is shown 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.

DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR NEVADA INDIVIDUAL CONVERSION STANDARD PLAN

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

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

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

T. Substance Abuse Benefits.

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

1. Substance Abuse Detoxification Benefits. Benefits include diagnosis, medical treatment and medical **Referral Services** (including **Referral Services** to appropriate ancillary services) by the **Member's PCP** or **Participating Behavioral Health Provider** for the abuse of or addiction to alcohol or drugs. Treatment for withdrawal from the physiological effects of substance abuse is subject to a \$1,500 maximum per calendar year.
2. Outpatient Substance Abuse Benefits. **Covered Benefits** for outpatient rehabilitation visits for substance abuse, up to a maximum benefit of \$2,500 per **Member** per calendar year. Benefits include: (1) **Physician**, psychologist, nurse, certified addictions counselor and trained staff services; (2) rehabilitation therapy and counseling; (3) family counseling and intervention; (4) psychiatric, psychological and medical laboratory tests; (5) drugs, medicines, equipment use and supplies.
3. Inpatient Substance Abuse Benefits. **Member** is entitled to coverage for inpatient care benefits for **Detoxification**, medical treatment and rehabilitation services for **Substance Abuse** or addiction from a **Participating** facility or **Hospital**. The following services are **Covered Benefits** up to a maximum benefit of \$9,000 per calendar year: (a) lodging and dietary services; (b) **Physicians**, psychologist, nurse, certified addictions counselor and trained staff services; (c) diagnostic x-ray; (d) psychiatric, psychological and medical laboratory testing; (e) drugs, medicines, equipment use and supplies.

U. Mental Health Benefits.

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

1. Outpatient. Coverage is subject to the maximum number of visits shown on the Schedule of Benefits, but not less than 20 visits per **Contract Year** to a psychiatrist, clinical psychologist, psychiatric nurse, or psychiatric social worker in individual, group or family therapy sessions for short-term, outpatient evaluative and crisis intervention mental health services.
2. Inpatient. Coverage for treatment of inpatient mental or nervous disorders upon referral by **Member's Primary Care Physician** or if provided or arranged for by the **Member's Participating Behavioral Health Provider**. Any inpatient stay without a prior referral or which is not arranged by the **Participating Mental Health Provider** is a non-covered service under this Contract. Coverage is subject to the maximum number of days, if any, shown on the Schedule of Benefits.

DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR NEVADA INDIVIDUAL CONVERSION STANDARD PLAN

3. Inpatient Benefit Exchange. When clinically approved, and authorized by **HMO**, the **Member** may exchange one 1 mental health inpatient day, if any, 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. The **Member** may exchange 1 inpatient day for 2 days of treatment in a **Partial Hospitalization** and/or outpatient ECT program in lieu of hospitalization up to the maximum benefit limitation upon approval by **HMO**

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

EXCLUSIONS AND LIMITATIONS

A. Exclusions.

The following services are not covered.

- Services for which coverage is not specifically provided, complications resulting from non-Covered Services, or services which are not **Medically Necessary**, whether or not recommended or provided by a **Provider**.
- Personal comfort, hygiene, or convenience items such as a **Hospital** television, telephone, or private room when not **Medically Necessary**. Housekeeping or meal services as part of Home Health Care. Modifications to a place of residence, including equipment to accommodate physical handicaps or disabilities.
- For a private room in excess of the average semi-private room and board rate.
- Dental or orthodontic splints or dental prostheses, or any treatment on or to teeth, gums, or jaws and other services customarily provided by a dentist. Charges for dental services in connection with temporomandibular joint dysfunction are also not covered unless they are determined to be **Medically Necessary**. Such dental-related services are subject to the limitation shown in the Schedule of Benefits.
- Except for reconstructive surgery following a mastectomy, cosmetic procedures to improve appearance without restoring a physical bodily function.
- Third-party physical exams for employment, licensing, insurance, school, camp, sports, or adoption purposes. Immunizations related to foreign travel. Expenses for medical reports, including presentation and preparation. Exams or treatment ordered by a court, or in connection with legal proceedings if not **Medically Necessary** or a covered service.
- For fertility or infertility studies, diagnostic testing, advice, consultation, examination, medication, or for any treatment related to or connected in any way with the restoration or enhancement of fertility or conception by artificial means including Embryo transplants, in vitro fertilization, GIFT and ZIFT procedures and low tubal transfers.
- For the treatment of sexual dysfunction or inadequacies, including, but not limited to, impotence and implantation of a penile prosthesis. Reversal of surgically performed sterilization or subsequent reesterilization. Charges for genetic testing, counseling, treatment or therapy.
- Elective abortions.

DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR NEVADA INDIVIDUAL CONVERSION STANDARD PLAN

- Surgical or invasive treatment (including gastric balloon) or reversal for reduction of weight regardless of associated medical or psychological conditions, unless determined to be **Medically Necessary**. Any weight loss programs, whether or not recommended, provided or prescribed by a **Physician** or other medical practitioner.
- Treatment of chronic marital or family problems; occupational, religious, or other social maladjustments; chronic behavior disorders; codependency; impulse control disorders, organic disorders, learning disabilities or mental retardation.
- Institutional care which is determined to be for the primary purpose of controlling **Member's** environment and **Custodial Care**, domiciliary care, convalescent care (other than skilled nursing care) or rest cures.
- Vision exams to determine refractive errors of vision and eye glasses or contact lenses. Coverage is provided for vision exams only when required to diagnose an illness or injury.
- Hearing exams to determine the need for or the appropriate type of hearing aid or similar. Coverage is provided for hearing exams only when required to diagnose an illness or injury.
- Ecological or environmental medicine. Use of chelation, orthomolecular substances; use of substances of animal, vegetable, chemical or mineral origin not specifically approved by the FDA as effective for treatment; electrodiagnosis; Hahnemannian dilution and succussion; magnetically energized geometric patterns; replacement of metal dental filling; laetrile; gerovital.
- Services for chronic, intractable pain by a pain control center or under a pain control program.
- Acupuncture or hypnosis.
- Treatment of an illness or injury resulting from riots, war, insurrection; rebellion; or armed invasion or aggression.
- Treatment of an occupational injury or illness which is any injury or illness arising out of or in the course of employment for pay or profit.
- Travel and accommodations, whether or not recommended or prescribed by a **Provider**.
- Vitamins, herbal medicines, appetite suppressants, and other over-the-counter drugs. Drugs and medicines approved by the FDA for experimental or investigational use.
- Any services provided before the **Effective Date of Coverage** or after the termination of coverage.
- Care for conditions that federal, state or local law requires to be treated in a public facility for which a charge is not normally made.
- Any equipment or supplies that condition the air, arch supports, support stockings, special shoe accessories or corrective shoes unless they are an integral part of a lower-body brace, hearing pads, hot water bottles, wigs and their care and other primarily nonmedical equipment.
- Special formulas, food supplements other than as specifically covered or special diets on an outpatient basis. (Except for the treatment of inherited metabolic disease)
- Services, supplies or accommodations provided without cost to the **Member** or which the **Member** is not legally required to pay.
- Milieu therapy, biofeedback, behavior modification, sensitivity training, hypnosis, hydrotherapy, electrohypnosis, electrosleep therapy, electonarcosis, narcosynthesis, rolffing, residential treatment, vocational rehabilitation and wilderness programs.

DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR NEVADA INDIVIDUAL CONVERSION STANDARD PLAN

- Experimental or investigational treatment or devices.
- Sports medicine treatment plans intended to primarily improve athletic ability.
- Radial keratotomy or any surgical procedure for the improvement of vision when vision can be made adequate through the use of glasses or contact lenses.
- Any services given by a **Provider** to himself or to members of his family.
- Ambulance services when a **Member** could be safely transported by other means. Air ambulance services when a member could be safely transported by ground ambulance or other means.
- Late discharge billing and charges resulting from a canceled appointment or procedure.
- Care or treatment of an illness or injury caused by or arising out of participation in a riot, war, insurrection, rebellion, armed invasion or aggression; or sustained by a **Member** while in the act of committing a felony.
- If you are eligible for Medicare, any services covered by Medicare under Parts A and B are excluded to the extent actually paid for by Medicare (applicable to individual coverage only).

B. Limitations.

- In the event there are two or more alternative **Medical Services** which in the sole judgment of **HMO** are equivalent in quality of care, **HMO** reserves the right to provide coverage only for the least costly **Medical Service**, as determined by **HMO**, provided that **HMO** approves coverage for the **Medical Service** or treatment in advance.
- Determinations regarding eligibility for benefits, coverage for services, benefit denials and all other terms of this **Certificate** are at the sole discretion of **HMO**, subject to the terms of this **Certificate**.

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

TERMINATION OF COVERAGE

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

A. Termination of Subscriber Coverage.

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

1. the **Certificate** terminates;
2. the **Subscriber** is no longer eligible as outlined in the Eligibility and Enrollment section of this **Certificate**;
3. the **Subscriber** terminates this **Certificate** on any **Premium** due date by giving 30 days' prior written notice;
4. the **Contract Holder** terminates this **Certificate** as of its renewal date, by providing **HMO** written notice of non-renewal not less than 30 days prior to the renewal date;

DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR NEVADA INDIVIDUAL CONVERSION STANDARD PLAN

5. the **Contract Holder** terminates this **Certificate** as of the date any **Premium** change would become effective, by providing **HMO** with written notice of termination not less than 30 days prior to such effective date; or
6. the **Subscriber's** eligibility for Medicare.

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 the Eligibility and Enrollment section of this **Certificate** and on the Schedule of Benefits;
2. the **Certificate** terminates;
3. the **Subscriber's** coverage terminates; or
4. The **Dependent's** eligibility for Medicare.

C. Termination For Cause.

HMO may terminate coverage for cause:

1. upon 31 days advance written notice in the event that **HMO** does not receive payment from the **Contract Holder** for the entire **Premium** due under this **Certificate** within the grace period. Coverage will terminate as of the last day for which **Premiums** were received, subject to the grace period. The termination of this **Certificate** following the expiration of the grace period shall not relieve the **Contract Holder** of its obligation to pay the **Premium** for coverage provided during the grace period.
2. upon 31 days advance written notice, if the **Member** has failed to make any required **Copayment** or any other payment which the **Member** is obligated to pay. Upon the effective date of such termination, prepayments received by **HMO** on account of such terminated **Member** or **Members** for periods after the effective date of termination shall be refunded to **Contract Holder**.
3. upon 31 days advance written notice of discovering a material misrepresentation by the **Member** in applying for or obtaining coverage or benefits under this **Certificate** or discovering that the **Member** has committed fraud against **HMO**. This may include, but is not limited to, furnishing incorrect or misleading information to **HMO**, or allowing or assisting a person other than the **Member** named on the identification card to obtain **HMO** benefits. **HMO** may, at its discretion, rescind a **Member's** coverage on and after the date that such misrepresentation or fraud occurred. It may also recover from the **Member** the reasonable and recognized charges for **Covered Benefits**, plus **HMO's** cost of recovering those charges, including reasonable attorneys' fees. In the absence of fraud or material misrepresentation, all statements made by any **Member** or any person applying for coverage under this **Certificate** will be deemed representations and not warranties. No statement made for the purpose of obtaining coverage will result in the termination of coverage or reduction of benefits unless the statement is contained in writing and signed by the **Member**, and a copy of same has been furnished to the **Member** prior to termination.

No termination shall relieve the **Contract Holder** from any obligation incurred prior to the date of termination 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 **Certificate** shall not deem the continuation of a **Members'** coverage beyond the date coverage terminates.

DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR NEVADA INDIVIDUAL CONVERSION STANDARD PLAN

A **Member** may request that **HMO** conduct a grievance hearing, as described in the Grievance Procedure section of this **Certificate**, within 15 working days after receiving notice that **HMO** has or will terminate the **Member's** coverage as described in the Termination For Cause subsection of this **Certificate**. **HMO** will continue the **Member's** coverage in force until a final decision on the grievance is rendered, provided the **Premium** is paid throughout the period prior to the issuance of that final decision. **HMO** may rescind coverage, to the date coverage would have terminated had the **Member** not requested a grievance hearing, if the final decision is in favor of **HMO**. If coverage is rescinded, **HMO** will refund any **Premiums** paid for that period after the termination date, minus the cost of **Covered Benefits** provided to a **Member** during this period.

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

CONTINUATION

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

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

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

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.

B. Rights of Dependents to Conversion Coverage.

1. A dependent shall be entitled to convert to an individual conversion policy if:
 - a. the dependent is not eligible to enroll in Medicare, or under any other state or federal law providing benefits similar to those provided by the conversion option; and
 - b. the dependent ceases to meet the eligibility requirements set forth in the Eligibility and Enrollment section of this **Certificate** and the Dependent Eligibility section of the Schedule of Benefits because of age, or divorce of the **Subscriber**, except that the newborn of a dependent-**Member** (e.g., grandchild) who is not eligible for coverage is entitled to individual conversion coverage.
2. A dependent shall not be entitled to convert to an individual policy if the **Subscriber** of the dependent, or the dependent has failed to apply and remit **Premium** payment for this conversion option within the 45 day period following loss of coverage.

DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR NEVADA INDIVIDUAL CONVERSION STANDARD PLAN

3. In the event of the death of the **Subscriber**, or the **Subscriber's** termination by the **HMO** for cause pursuant to the Termination of Coverage section of this **Certificate**, the spouse and/or dependent(s) will automatically become the **Subscriber** of this **Certificate** and there will be no need for the surviving dependent(s) to apply for individual conversion coverage.
4. The dependent may convert to an individual policy if the dependent:
 - a. applies to **HMO** within 45 days after the effective date of termination;
 - b. makes the applicable **Premium** payment; and
 - c. continues to make the applicable **Premium** payments.
5. **HMO** is not responsible for giving the **Member** notice of the conversion option. Forms for conversion, including the enrollment and change form and the health questionnaire, where applicable, are available from **HMO**. The first **Premium** payment must also be received within 45 days of the effective date of termination. Individual policy coverage will not be effective if the application and **Premium** payment are not received within 45 days of the effective date of termination. Benefits will be the same as the benefits listed in the Covered Benefits section of this **Certificate**.
6. The **Effective Date of Coverage** for conversion to an individual policy coverage shall be the date coverage is terminated under this **Certificate** if the enrollment and change form and **Premium** payment are received within 45 days of the effective date of termination. Coverage will continue in accordance with the terms of this **Certificate**.

GRIEVANCE PROCEDURE

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

A. Definitions.

1. An "inquiry" is a **Member's** request for administrative service, information, or to express an opinion, including but not limited to, claims regarding scope of coverage for health services, denials, cancellations, terminations or renewals, and the quality of services provided.
2. A "grievance" is a complaint that may or may not require specific corrective action, and is made in writing to **HMO**, or an inquiry which remains unresolved after a 60 day period after receipt of HMO.

B. Grievance Review.

1. A written notice shall be sent by **HMO** to the **Member**:
 - i. acknowledging each grievance; and
 - ii. inviting the **Member** to provide any additional information to assist **HMO** in handling and deciding the grievance; and
 - iii. informing the **Member** of the **Member's** right to have an uninvolved **HMO** representative assist the **Member** in understanding the grievance process; and
 - iv. informing the **Member** as to when a response should be forthcoming.
2. The Grievance Coordinator deciding the grievance shall be comprised of one or more employees of **HMO**. It shall not include any person whose decision is being appealed, any person who made the initial decision regarding the claim, or any person with previous involvement with the grievance. The Grievance Committee shall review and decide the grievance within 30 days of receipt unless additional information necessary to resolve the grievance is not received during such time, or by the mutual written agreement of **HMO** and the **Member**.

DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR NEVADA INDIVIDUAL CONVERSION STANDARD PLAN

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 if the **Member** is not satisfied with the Grievance Coordinator's decision, the **Member** has the right to appeal in writing to the Grievance Appeal Committee within 30 days of the date of the notice of the decision to the Grievance coordinator; and
 - ii. a description of the process of how to appeal to the Grievance Appeal Committee; and

C. 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, one of whom shall be a non-employee **Subscriber** of the **HMO**. The Grievance Appeal Committee shall not include any person previously involved with the grievance. An **HMO** Medical Director may serve as a member of the Committee if the Medical Director was not previously involved with the grievance.
3. The Grievance Appeal Committee shall hold appeal hearings in **HMO** offices on a certain day each month to consider all appeals filed seven business days or more in advance of the hearing day. In the event a **Member** is unable to attend the hearing on the scheduled hearing day, the **Member** may request that their appeal be heard on the next scheduled hearing day. If no scheduled hearing day is suitable for the **Member**, the hearing will be scheduled for the following month.
4. The **Member** shall have the right to attend the appeal hearing, question the representative of **HMO** designated to appear at the hearing and any other witnesses, and present their case. The **Member** shall also have the right to be assisted or represented by a person of the **Member's** choice, and submit written material in support of their grievance. The **Member** may bring a **Physician** or other expert(s) to testify on the **Member's** behalf. **HMO** shall also have the right to present witnesses. Counsel for the **Member** may present the **Member's** case and question witnesses; if the **Member** is so represented, **HMO** may be similarly represented by counsel. The Grievance Appeal Committee shall have the right to question the **HMO** representative, the **Member** and any other witnesses.
5. The appeal hearing shall be informal. The Grievance Appeal Committee shall not apply formal rules of evidence in reviewing documentation or accepting testimony at the hearing. The Chair of the Grievance Appeal Committee shall have the right to exclude redundant testimony or excessive argument by any party or witness.

**DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR
NEVADA INDIVIDUAL CONVERSION STANDARD PLAN**

6. A written record of the appeal hearing shall be made by stenographic transcription. All testimony shall be under oath.
7. Before the record is closed, the Chair of the Grievance Appeal Committee shall ask both the **Member** and the **HMO** representative (or their counsel) whether there is any additional evidence or argument which the party wishes to present to the Grievance Appeal Committee. Once all evidence and arguments have been received, the record of the appeal hearing shall be closed. The deliberations of the Grievance Appeal Committee shall be confidential and shall not be transcribed.
8. The Grievance Appeal Committee shall render a written decision within 30 working days of the conclusion of the appeal hearing. The decision shall contain:
 - a. a statement of the Grievance - Appeal Committee's understanding of the nature of the grievance and the material facts related thereto; and
 - b. the Grievance Appeal Committee's decision and rationale; and
 - c. a summary of the evidence, including necessary document supporting the decision; and
 - d. a statement of the **Member's** right to appeal to the Department of Insurance, with the phone number and complete address of the Department of Insurance.

D. Emergency or Urgently Needed Care.

1. In the event a complaint requires specific action, and the **Member** or **HMO** believes serious medical consequences will arise in the near future, within up to 15 days from **HMO's** denial to pay for the provision of allegedly **Medically Necessary** covered health services, the **Member** shall receive expedited review of their complaint.
2. In the event the issue is of an emergent nature, an **HMO** Medical Director shall review the matter as soon as possible or within 48 hours, and communicate a decision to the **Member** by telephone.
3. In the event the issue is of an urgent nature, an **HMO** Medical Director shall review the matter and make a determination within 96 hours of receipt.
4. An adverse decision by a Medical Director in either an emergent or urgent medical situation shall be immediately reviewed by an **HMO** Regional Medical Director or his designee. The decision of the Regional Medical Director shall be provided to the **Member** by telephone and confirmed in writing.

E. Exhaustion of Process.

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

1. any investigation of a complaint by the Department of Insurance; or
2. the filing of a complaint with the Department of Insurance; or
3. the establishing of any litigation or arbitration, or any administrative proceeding regarding either any alleged breach of the **Certificate** by **HMO**, or any matter within the scope of the grievance resolution process of any complaint, grievance or grievance appeal.

However, a **Member** can file a complaint with the Division of Insurance at any time. The complaint should be filed at the Nevada Division of Insurance, 1665 Hot Springs Road #152, Carson City, NV 89710, phone (702) 687-4270, at the Nevada Department of Insurance Toll-free consumer line **1-888-872-3234** or 1-800-992-0900 or in Las Vegas at the Nevada Division of Insurance, 2501 E. Sahara Ave. #302, Las Vegas, NV 89158, phone (702) 486-4009.

**DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR
NEVADA INDIVIDUAL CONVERSION STANDARD PLAN**

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

G. Fees and Costs.

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

COORDINATION OF BENEFITS

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

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

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

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

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

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

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

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

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

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

1. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (C) above will apply.
2. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

**DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR
NEVADA INDIVIDUAL CONVERSION STANDARD PLAN**

3. If there is not such a court decree: If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

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

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

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

1. laid-off or retired employee; or
2. the dependent of such person; shall be determined after the benefits of any

other plan which covers such person as:

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

other plan does not have a provision:

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

then the above paragraph will not apply.

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

If the other plan does not have a provision:

1. regarding right of continuation pursuant to federal or state law; and
2. as a result, each plan determines its benefits after the other, then the above paragraph will not apply.

HMO has the right to release or obtain any information and make or recover any payment it considers necessary in order to administer this provision.

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

1. Group insurance.
2. Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
3. Government programs or Workmen's Compensation.

DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR NEVADA INDIVIDUAL CONVERSION STANDARD PLAN

Payment of Benefits.

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

Facility of Payment.

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

Recovery of Overpayments.

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

Federal Or State Government Programs.

The coverage under this **Certificate** is not intended to duplicate any benefits for which **Members** are, or could be, eligible for under any other federal or state government programs (such as Workers' Compensation). All sums payable under such programs for services provided 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 any other government programs for which **Members** are eligible.

RESPONSIBILITY OF MEMBERS

- A. **Members** or applicants shall complete and submit to **HMO** such application or other forms or statements as **HMO** may reasonably request. **Members** represent that all information contained in such applications, forms and statements submitted to **HMO** incident to enrollment under this **Certificate** or the administration herein shall be true, correct, and complete to the best of the **Member's** knowledge and belief.
- B. The **Member** shall notify **HMO** immediately of any change of address for the **Member** or any of the **Member's Covered Dependents**.
- C. The **Member** understands that **HMO** is acting in reliance upon all information provided to it by the **Member** at time of enrollment and afterwards and represents that information so provided is true and accurate.
- D. By electing coverage pursuant to this **Certificate**, or accepting benefits hereunder, all **Members** who are legally capable of contracting, and the legal representatives of all **Members** who are incapable of contracting, at time of enrollment and afterwards, represent that all information so provided is true and accurate and agree to all terms, conditions and provisions hereof.
- E. **Members** are subject to and shall abide by the rules and regulations of each **Provider** from which benefits are provided.

DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR NEVADA INDIVIDUAL CONVERSION STANDARD PLAN

GENERAL PROVISIONS

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

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

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

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

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

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

E. Independent Contractor Relationship.

1. The relationship between HMO and Participating Providers is a contractual relationship among independent contractors. No Participating Provider or other Provider, institution, facility or agency is an agent or employee of HMO. Neither HMO nor any Member of HMO is an agent or employee of any Participating Provider or other Provider, institution, facility or agency.
2. Neither the Contract Holder nor a Member is the agent or representative of HMO, its agents or employees, or an agent or representative of any Participating Provider or other person or organization with which HMO has made or hereafter shall make arrangements for services under this Certificate.

**DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR
NEVADA INDIVIDUAL CONVERSION STANDARD PLAN**

3. **Participating Physicians** maintain the physician-patient relationship with **Members** and are solely responsible to **Member** for all **Medical Services** which are rendered by **Participating Physicians** to their **Member** patients. **HMO** makes no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any **Physician, Hospital** or other **Participating Provider**. A **Provider's** participation may be terminated at any time without advance notice to the **Contract Holder** or **Members**.
 4. **HMO** cannot guarantee the continued participation of any **Provider** or facility with **HMO**. In the event a **PCP** terminates its contract or is terminated by **HMO**, **HMO** shall provide notification to **Members** in the following manner:
 - a. within 31 days of the termination of a **PCP** contract to each affected **Subscriber**, if the **Subscriber** or any **Dependent** of the **Subscriber** is currently enrolled in the **PCP's** office; and
 - b. services rendered by a **PCP** or **Hospital** to an enrollee between the date of termination of the Provider Agreement and five business days after notification of the contract termination is mailed to the **Member** at the **Member's** last known address shall continue to be **Covered Benefits**.
 5. **Restriction on Choice of Providers:** Unless otherwise approved by **HMO**, **Members** must utilize **Participating Providers** and facilities who have contracted with **HMO** to provide services.
- F. **Inability to Provide Service.** In the event that due to circumstances not within the reasonable control of **HMO**, including but not limited to, major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of the Participating Provider Network, the rendition of medical or **Hospital** benefits or other services provided under this **Certificate** is delayed or rendered impractical, **HMO** shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid **Premiums** held by **HMO** on the date such event occurs. **HMO** is required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event, including making arrangements for **Members** for covered services payments made other than any applicable copayments.
- G. **Confidentiality.** Information contained in the medical records of **Members** and information received from **Physicians**, surgeons, **Hospitals** or other **Health Professionals** incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential in accordance with applicable law. Information may not be disclosed without the consent of the Member except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary by **HMO** in connection with the administration of this **Certificate**, or in the compiling of aggregate statistical data.
- H. **Limitation on Services.** Except in cases of a **Medical Emergency**, as provided under the Covered Benefits section of this **Certificate**, services are available only from **Participating Providers**. **HMO** shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a **Member** from any **Physician, Hospital, Skilled Nursing Facility**, home health care agency, or other person, entity, institution or organization unless prior arrangements are made by **HMO**.
- I. **Incontestability.** In the absence of fraud, all statements made by a **Member** shall be considered representations and not warranties, and no statement shall be the basis for voiding coverage or denying a claim after the **Certificate** has been in force for 2 years from its effective date, unless the statement was material to the risk and was contained in a written application.
- J. This **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**.
- K. This **Certificate** shall be subject to amendment, modification or termination in accordance with any provision hereof, by operation of law, by filing with and approval by the state Department of Insurance. This can also be done by mutual written agreement between **HMO** and **Contract Holder** without the consent of **Members**.

**DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR
NEVADA INDIVIDUAL CONVERSION STANDARD PLAN**

- L. **HMO** may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this **Certificate**.
- M. 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.
- N. This **Certificate**, including the Enrollment Form, Cover Sheet, Schedule of Benefits, and any amendments, endorsements, inserts, or attachments, constitutes the entire **Certificate** between the parties hereto pertaining to the subject matter hereof and supersedes all prior and contemporaneous arrangements, understandings, agreements, negotiations and discussions of the parties with respect to the subject matter hereof, whether written or oral; and there are no warranties, representations, or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth herein. No supplement, modification or waiver of this **Certificate** shall be binding unless executed in writing by an authorized representative.

All statements made by the **Contract Holder** or a **Member** shall be deemed representations and not warranties. No written statement made by a **Member** shall be used by **HMO** in a contest unless a copy of the statement is or has been furnished to the **Member** or his or her beneficiary, or the person making the claim.

This **Certificate** is subject to all rules and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over **HMO**, and this **Certificate** shall be deemed to be amended to conform therewith at all times. This **Certificate** may be changed at any time for any other reason by agreement between **HMO** and the **Contract Holder**, without the consent of any **Member** or other person. Except as detailed below, any amendments to this **Certificate** shall be in writing and must be approved and executed by authorized representatives of both the **Contract Holder** and **HMO**. No other individual has the authority to modify this **Certificate**; waive any of its provisions, conditions, or restrictions; extend the time for making a payment; or bind **HMO** by making any other commitment or representation or by giving or receiving any information. No change in this **Certificate** shall be valid unless evidenced by an endorsement, signed by an authorized representative of **HMO**.

Formal acceptance of an amendment to this **Certificate** by the **Contract Holder** shall not be required if:

1. the change was requested by either the **Contract Holder** or **HMO** and is agreed to in writing by the other; or
 2. the change is required to bring the **Certificate** into conformance with any applicable federal or state law or regulation, or ruling of the jurisdiction in which the **Certificate** is delivered; or
 3. the **Contract Holder** makes payment of any applicable **Premium** on and after the effective date of such amendment.
- O. This **Certificate** has been entered into and shall be construed according to applicable state and federal law.
- P. Incorrect information furnished to **HMO** may be corrected, provided that **HMO** has not acted to its prejudice in reliance thereon. Clerical errors or delays in keeping or reporting data relative to coverage will neither invalidate coverage which would otherwise be in force, continue coverage which would otherwise be validly terminated if **HMO**, in its sole discretion, determines that a clerical error has been made, nor grant additional benefits to **Members**. Upon discovery of such errors or delay, an adjustment of **Premiums** shall be made. In no case will adjustments in coverage or **Premiums** be made effective more than 2 **Premium** due dates prior to the date **HMO** is notified in writing, on a form satisfactory to **HMO**, of the requested addition, deletion, or change in coverage.

**DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR
NEVADA INDIVIDUAL CONVERSION STANDARD PLAN**

- Q.** HMO has complete authority to review all claims for **Covered Benefits** under this **Certificate**. In exercising such responsibility, HMO shall have discretionary authority to determine whether and to what extent eligible individuals and beneficiaries are entitled to coverage and construe any disputed or doubtful terms under this **Certificate**. HMO shall be deemed to have properly exercised such authority unless HMO abuses its discretion by acting arbitrarily and capriciously.
- R.** Except as to a fraudulent misstatement, or issues concerning **Premiums** due:
1. no statement made by the **Contract Holder** or any **Member** shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing.
 2. no statement made by the **Contract Holder** shall be the basis for voiding this **Certificate** after it has been in force for 2 years from its effective date.
 3. no statement made by a **Member** shall be used in defense of a claim for loss incurred or commencing after coverage has been in effect for 2 years.
- S.** No rights or benefits under this **Certificate** are assignable by the **Contract Holder** to any other party unless approved by HMO.
- T.** HMO's failure to implement, or insist upon compliance with, any provision of this **Certificate**, at any given time or times, shall not constitute a waiver of HMO's right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of **Premiums** or benefits. This applies whether or not the circumstances are the same.
- U.** Any notice required or permitted under this **Certificate** shall be in writing and shall be deemed to have been given on the date when delivered in person; or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid, and properly addressed to the address set forth in the Enrollment Form, or Cover Sheet, or to any more recent address of which the sending party has received written notice.
- V.** This **Certificate** shall not confer any rights or obligations on third parties except as specifically provided herein.
- W.** This **Certificate** shall be executed by HMO and the **Contract Holder** once the Enrollment Form, which is attached hereto and fully incorporated herein by reference, is completed and signed. However, payment of the applicable **Premium** on and after the effective date of this **Certificate** shall constitute execution of this **Certificate** by the **Contract Holder**.

PREMIUMS

- A.** **Premiums** for the **Covered Benefits** under this **Certificate** are set forth in the Cover Sheet attached hereto, which is fully incorporated herein by reference.
- B.** The **Premiums** set forth in the Cover Sheet shall be effective for the initial term of this **Certificate**. Thereafter, if HMO gives a minimum of 30 days prior written notice to the **Contract Holder**, HMO may change the **Premiums**:
- upon the renewal date of this **Certificate**; or
 - upon the effective date of any applicable law or regulation having a direct and material impact on the cost of providing coverage to **Members**.

Payment of the applicable **Premium** on and after that date shall constitute acceptance of those changes by the **Contract Holder**, individually and on behalf of all **Members** enrolled under this **Certificate**.

DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR NEVADA INDIVIDUAL CONVERSION STANDARD PLAN

- C. **Premiums** are payable to **HMO** on or in advance of each **Premium** due date at the corporate offices of **HMO** unless otherwise specified by **HMO** in writing. The payment of any **Premium** shall not maintain coverage under this **Certificate** in force beyond the date when the next payment becomes due; however, a 31 day grace period, during which time this **Certificate** will remain in force, shall be granted for payment of each amount due after the first. The **Contract Holder** shall remain liable for the payment of the **Premium** for the time coverage was in effect during the grace period and the **Member** shall remain liable for **Copayments** owed. A check is not a payment until it is honored by a bank. **HMO** reserves the right to return a check issued against insufficient funds without resorting to a second deposit attempt.
- D. **Premiums** shall be paid in full for **Members** whose coverage is effective on the **Premium** due date or whose coverage terminates on the last day of the **Premium** period.
- E. If the **Premiums** are not paid by the end of the 31 day grace period, the **Member's** coverage will end.

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.** Any necessary and reasonable health expense, part or all of which is covered under any of the plans covering the **Member** for whom claim is made.
- **Certificate.** The Individual Conversion Certificate of Coverage between **HMO** and the **Contract Holder**, including the Enrollment Form, Cover Sheet, this **Certificate**, the Schedule of Benefits, any amendments or endorsements, and any attachments, as subsequently amended by operation of law and as filed with and approved by the applicable public authority, which outlines coverage for a **Subscriber** and **Covered Dependents**.
- **Contract Holder.** A **Subscriber** who agrees to remit the **Premiums** for coverage under this **Certificate** payable to **HMO**. The **Contract Holder** shall act only as an agent of **HMO Members** in the **Contract Holder's** family, and shall not be the agent of **HMO** for any purpose.
- **Contract Year.** A period of one year commencing on the **Contract Holder's Effective Date of Coverage** and ends at 12:00 midnight on the last day of the one year period.
- **Coordination of Benefits.** A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing the authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first. Refer to the Coordination of Benefits section of this **Certificate** for a description of the **Coordination of Benefits** provision.
- **Copayment.** A specified dollar amount or percentage required to be paid by or on behalf of a **Member** in connection with benefits, if any, as set forth in the Schedule of Benefits. **Copayments** may be changed by **HMO** upon 30 days written notice to the **Contract Holder**.
- **Copayment Maximum.** The maximum annual out-of-pocket amount for payment of **Copayments**, if any, to be paid by a **Subscriber** and any **Covered Dependents**, if any.

DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR NEVADA INDIVIDUAL CONVERSION STANDARD PLAN

- **Cosmetic Surgery.** Any non-medically necessary surgery or procedure whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem, but which does not restore bodily function, correct a diseased state, physical appearance, or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. **Cosmetic Surgery** includes, but is not limited to, ear piercing, rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of **Cosmetic Surgery**.
- **Covered Dependent.** Any person in a **Subscriber's** family who meets all the eligibility requirements of the Eligibility and Enrollment section of this **Certificate** and the Dependent Eligibility section of the Schedule of Benefits, has enrolled in **HMO**, and is subject to **Premium** requirements set forth in the Premiums section of this **Certificate**.
- **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 this **Certificate**.
- **Custodial Care.** 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. **Custodial Care** includes, but is not limited to, 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. any type of care Examples of this includes, but is not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non infected, post operative or chronic conditions, preparation of special diets, supervision of medication which can be self-administered by the **Member**, general maintenance care of colostomy or ileostomy, routine services to maintain other service which, in the sole determination of **HMO**, based on medically accepted standards, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical or paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest cures, convalescent care
- **Detoxification.** The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed **Physician**, while keeping the physiological risk to the patient at a minimum.
- **Durable Medical Equipment.** Equipment, as determined by **HMO**, which is a) made to withstand prolonged use; b) made for and mainly used in the treatment of a disease or injury; c) suited for use while not confined as an inpatient in the **Hospital**; d) not normally of use to persons who do not have a disease or injury; e) not for use in altering air quality or temperature; and f) not for exercise or training.
- **Effective Date of Coverage.** The commencement date of coverage under this **Certificate** as shown on the records of **HMO**.
- **Emergency Service.** Professional health services that are provided to treat a **Medical Emergency**.
- **Experimental or Investigational Procedures.** Services or supplies that are, as determined by **HMO**, experimental. A drug, device, procedure or treatment will be determined to be experimental if:
 1. there is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
 2. required FDA approval has not been granted for marketing; or

DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR NEVADA INDIVIDUAL CONVERSION STANDARD PLAN

3. a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or
 4. the written protocol or protocol(s) used by the treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or
 5. it is not of proven benefit for the specific diagnosis or treatment of a **Member's** particular condition; or
 6. it is not generally recognized by the **Medical Community** as effective or appropriate for the specific diagnosis or treatment of a **Member's** particular condition; or
 7. it is provided or performed in special settings for research purposes.
- **Health Professionals.** A **Physician** or other professional who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides **Medical Services** which are within the scope of the individual's license or certificate.
 - **HMO.** Aetna Health, Inc. is an Arizona corporation licensed by the Nevada Department of Insurance as a Health Maintenance Organization .
 - **Homebound Member.** A **Member** who is confined to the home due to an illness or injury which makes leaving the home medically contraindicated or which restricts the **Member's** ability to leave the **Member's** place of residence except with the aid of supportive devices, the use of special transportation, or the assistance of another person.
 - **Home Health Services.** Those items and services provided by **Participating Providers** as an alternative to hospitalization, and approved and coordinated in advance by **HMO**.
 - **Hospice Care.** A program of care that is provided by a **Hospital, Skilled Nursing Facility**, hospice, or a duly licensed Hospice Care agency, and is approved by **HMO**, and is focused on a palliative rather than curative treatment for **Members** who have a medical condition and a prognosis of less than 6 months to live.
 - **Hospital.** An institution rendering inpatient and outpatient services, accredited as a **Hospital** by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by **HMO** as meeting reasonable standards. A **Hospital** may be a general, acute care, rehabilitation or specialty institution.
 - **Infertile or Infertility.** The condition of a presumably healthy **Member** who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual sexual intercourse. This does not include conditions for male **Members** when the cause is a vasectomy or orchiectomy or for female **Members** when the cause is a tubal ligation or hysterectomy.
 - **Medical Community.** A majority of **Physicians** who are Board Certified in the appropriate specialty.
 - **Medical Emergency.** 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.

DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR NEVADA INDIVIDUAL CONVERSION STANDARD PLAN

- **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.** A **Subscriber** or **Covered Dependent** as defined in this **Certificate**.
- **Mental or Behavioral Condition.** A condition which manifests signs and/or symptoms which are primarily mental or behavioral, for which the primary treatment is psychotherapy, psychotherapeutic methods or procedures, and/or the administration of psychotropic medication, regardless of any underlying physical or medical cause. Mental or behavioral disorders and conditions include, but are not limited to, psychosis, affective disorders, anxiety disorders, personality disorders, obsessive-compulsive disorders, attention disorders with or without hyperactivity, and other psychological, emotional, nervous, behavioral, or stress-related abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems, whether or not caused or in any way resulting from chemical imbalance, physical trauma, or a physical or medical condition.
- **Non-Hospital Facility.** A facility, licensed by the appropriate regulatory authority, for the care or treatment of alcohol or drug dependent persons, except for transitional living facilities.
- **Partial Hospitalization.** The provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a **Hospital** or **Non-Hospital Facility** which is licensed as an alcohol or drug abuse or mental illness treatment program by the appropriate regulatory authority, and which is designed for a patient or client who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care.
- **Participating.** A description of a **Provider** that has entered into a contractual agreement with **HMO** for the provision of services to **Members**.
- **Physician.** A duly licensed member of a medical profession, who has an M.D. or D.O. degree, who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides **Medical Services** which are within the scope of the individual's license or certificate.
- **Premium.** The amount the **Contract Holder** or **Member** is required to pay to **HMO** to continue coverage.
- **Primary Care Physician.** A **Participating Physician** who supervises, coordinates and provides initial care and basic **Medical Services** as a general or family care practitioner, or in some cases, as an internist or a pediatrician to **Members**, initiates their **Referral** for **Specialist** care, and maintains continuity of patient care.
- **Provider.** A **Physician, Health Professional, Hospital, Skilled Nursing Facility**, home health agency or other recognized entity or person licensed 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.

DISCLOSURE BROCHURE AND SAMPLE CERTIFICATE OF COVERAGE FOR NEVADA INDIVIDUAL CONVERSION STANDARD PLAN

- **Respite Care.** Care furnished during a period of time when the **Member's** family or usual caretaker cannot, or will not, attend to the **Member's** needs.
- **Service Area.** The geographic area, established by **HMO** and approved by the appropriate regulatory authority.
- **Skilled Care.** Medical care that requires the skills of technical or professional personnel.
- **Skilled Nursing Facility.** An institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing skilled nursing care and related services as a **Skilled Nursing Facility**, extended care facility, or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by **HMO** to meet the reasonable standards applied by any of the aforesaid authorities.
- **Specialist.** A **Physician** who provides medical care in any generally accepted medical or surgical specialty or subspecialty.
- **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 this **Certificate**.
- **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 an occupation for which the **Member** is reasonably fitted by training, experience and accomplishments; or
 2. the **Member** is a **Covered Dependent** and is prevented because of injury or disease, from engaging in substantially all of the normal activities of a person of like age and sex in good health.
- **Urgent Care. Covered Benefits** required in order to prevent serious deterioration of a **Member's** health that results from an unforeseen illness or injury if the **Member** is temporarily absent from the **HMO Service Area** and receipt of the health care service cannot be delayed until the **Member's** return to the **Service Area**.