MARKET CONDUCT EXAMINATION

AETNA HEALTH INC.

600 UNIVERSITY STREET, SUITE 1400
SEATTLE, WASHINGTON 98101

January 1, 2005 – May 31, 2006

Order No. G 08-0012
Aetna Health, Inc.
Exhibit A

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The Honorable Mike Kreidler
Washington State Insurance Commissioner
302 14th Avenue SW
P.O. Box 40258
Olympia, Washington 98504-0258

Dear Commissioner Kreidler:

Pursuant to your instructions and in compliance with the statutory requirements of RCW 48.44.145 and procedures promulgated by the National Association of Insurance Commissioners and the Office of the Insurance Commissioner (OIC), an examination of the market conduct affairs has been performed of:

Aetna Health Inc., NAIC 47060
600 University Street, Suite 1400
Seattle, WA 98101

In this report, Aetna Health Inc. is referred to as the Company.

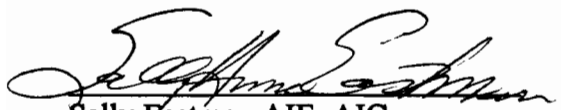
This report of examination is respectfully submitted.

CHIEF EXAMINER'S REPORT CERTIFICATION and ACKNOWLEDGEMENTS

This examination was conducted in accordance with Office of Insurance Commissioner and National Association of Insurance Commissioners market conduct examination procedures. Sandy Ray, CIE, CPCU; Jeanette M. Plitt, AIE, CLU; and Juanita M. Labosier of the Washington State Office of Insurance Commissioner performed this examination and participated in the preparation of this report.

The examiners wish to express appreciation for the courtesy and cooperation extended by the personnel of Aetna Health Inc. during the course of this market conduct examination.

I certify that this document is the report of the examination, that I have reviewed this report in conjunction with pertinent examination work papers, that this report meets the provisions for such reports prescribed by the Office of Insurance Commissioner and that this report is true and correct to the best of my knowledge and belief.



Sally Eastman AIE, AIC
Chief Market Conduct Examiner
Office of the Insurance Commissioner
State of Washington

FOREWORD

This examination was completed by applying tests to each examination standard. Each test applied during the examination is stated in this report and the results are reported. Exceptions are noted as part of the comments for the applied test. Throughout the report, where cited, RCW refers to the Revised Code of Washington, and WAC refers to Washington Administrative Code.

Prior Examination Summary

This is the second market conduct examination of Aetna Health Inc. The prior examination of Aetna Health Inc., and Aetna Health of Washington Inc., was adopted in 2003.
The Company was issued instructions on the following findings:

- Failure to submit copies of changes to its registration documents to the OIC
- Failure to ensure the composition of its Board of Directors allows meaningful representation from its enrolled participants.
- Failure to provide timely responses to communications from the OIC.
- Failure to ensure agents and brokers are licensed for the appropriate line of business with the State of Washington prior to solicitation of business or represent the Company in any way.
- Failure to immediately distribute provider contract amendments to all of its providers so that each contract contains prescribed standards.
- Failure to include the prescribed definition for emergency medical condition in each of its provider contracts.
- Failure to maintain a complete advertising file
- Failure to file rates with the OIC prior to use and implement filed rates into its computer quoting systems.
- Failure to file provider contract forms with the OIC prior to use.

The Company was also instructed to comply as follows:

- Immediately implement or withdraw filed Magellan Behavioral Health contract.
- Facilitate future examinations by providing accurate, meaningful information and timely responses to the examiners
- Amend contract language in future filings to;
    - Clarify process in regard to mammograms
    - State both emergency care and direct access benefits are available even if PCP is not selected
    - Clarify procedures for follow up treatment to emergency care.
    - Clarify provisions regarding premium payment by the member during a labor dispute.
    - Clarify provisions concerning continuation of coverage after termination from a group plan.
    - Company must include hold harmless language in its provider contracts.

The examiners did not identify any repeat violations in areas that were common to both exams.

Scope

Time Frame

The examination covered the Company's operations from January 1, 2005 through May 31, 2006. This examination was performed in the Seattle OIC office and at the office of Aetna Health Inc.

Matters Examined

The examination included a review of the following areas:

Company Operations and Management	Claims
Complaints	Rate and Form Filing
Provider Activity	Underwriting

Sampling Standards

Methodology

In general, the sample for each test utilized in this examination falls within the following guidelines:

92 %	Confidence Level
+/- 5 %	Mathematical Tolerance

These are the guidelines prescribed by the National Association of Insurance Commissioners in the Market Regulation Handbook.

Regulatory Standards

Market Conduct samples are tested for compliance with standards established by the OIC. The tests applied to sampled data will result in an error ratio, which determines whether or not a standard is met. If the error ratio found in the sample is, generally, less than 5%, the standard will be considered as met. The standards in the area of agent licensing and appointment, and policy and form filings will not be met if any violation is identified. This will also apply when all records are examined, in lieu of a sample.

For those standards, which look for the existence of written procedures, or a process to be in place, the standard will be met based on the examiner's analysis of those procedures or processes. The analysis will include a determination of whether or not the company follows established procedures.

Standards will be reported as Passed (without Comment), Passed with Comment or Failed. The definition of each category follows:

Passed	There were no findings for the standard.
Passed with Comment	Errors in the records reviewed fell within the tolerance level for that standard.
Failed	Errors in the records reviewed fell outside of the tolerance level established for the standard.

COMPANY OPERATIONS AND MANAGEMENT

Company History

Aetna Health Inc. (a Washington corporation), formerly Aetna Health of Washington Inc., is a wholly-owned subsidiary of NYLCare Health Plans, Inc. The ultimate parent is Aetna Inc.

Effective December 31, 2003, Aetna Health Inc. a Washington corporation registered as a Health Maintenance Organization (HMO), merged with and into Aetna Health of Washington Inc., a Washington corporation registered as a Health Care Service Contractor (HCSC). The surviving company of the Merger was the HCSC, Aetna Health of Washington Inc., which changed its name to Aetna Health Inc. effective with the merger.

The Company is incorporated in the State of Washington and commenced operations as a Health Care Services Contractor in 1995.

Company Operations and Management

Aetna Health Inc. is governed by a three (3) member Board of Directors. The current members of the board are:

Board Member	Term Began
Phillip Jeffrey Haas	6/29/2004
Milton Dorian Schwarz, M.D.	12/17/2001
Norman Seabrooks	12/17/2001

The Company states that the Board of Directors terms do not expire.

Territory of Operations

The Company is a Health Care Service Contractor and is licensed to transact business in all counties in the state of Washington. The Company's operations include small group, large group and Federal health benefit plans.

Findings

The following Company Operations and Management Standards passed without comment:

1	**The Company is required to be registered with the OIC prior to acting as a health care service contractor in the State of Washington.**	**RCW 48.44.015(1)**

2	**The Company is required to report to the OIC any changes to the registration documents, including Articles of Incorporation, Bylaws, and Amendments at the same time as submitting such documents to the Secretary of State.**	**RCW 48.44.013**
3	**When the Company registers with the OIC, it is required to state its territory of operations.**	**RCW 48.44.040**
4	**The Company shall not advertise or display its certificate of registration for use as an inducement in any solicitation.**	**RCW 48.44.150**

The following Company Operations and Management Standard failed:

5	**The Company is required to be registered with the Office of Insurance Commissioner prior to acting as a health maintenance organization in the State of Washington.**	**RCW 48.46.027(1)**

Company Operations and Management Standard 5: Throughout the examination it was found that the Company referred to itself as a Health Maintenance Organization (HMO) rather than a health care service contractor (HCSC). References to HMO were found in the following:

- May 27, 2005 Board Meeting Minutes – Reference is made to HMO membership.
- The Company references member plans as being fully insured HMO plans in responses it sends to member complaints.
- The Company claims system is a nationwide system and identifies products as either "HMO" products or "Non-HMO" products, Washington products fall into the HMO category for claim processing purposes.
- In response to the OIC request for a claims procedures manual the reply included a statement indicating that the Company maintains all HMO claims processing alerts, directives, policy and procedures as an online reference manual for research and guidance.

The Company does provide a document to its staff outlining the 2003 merger of its two legal entities in Washington which explains that the remaining entity is licensed as an HCSC and covers the issues associated with the resultant change of its plan name from HMO to Primary Choice. The document can be found within the Company's OnLine Reference System which must be accessed by the employee. It does not appear that this document has effectively communicated that the Company is solely licensed as an HCSC in the state of Washington.

GENERAL EXAMINATION FINDINGS

The Company's records and operations were reviewed to determine if the Company does business in accordance with the requirements of this state.

Findings

The following General Examination Standard passed without comment:

1	**The Company does business in good faith, and practices honesty and equity in all transactions.**	**RCW 48.01.030**
3	**The Company may not discourage members from contacting the OIC and may not discriminate against those members that do contact the OIC.**	**WAC 284-30-572(2)**

The following General Examination Standards passed with comment:

2	**The Company must facilitate the examination process by providing its accounts, records, documents and files to the examiners upon request.**	**RCW 48.44.145(2)**
4	**No person shall knowingly make, publish, or disseminate any false, deceptive or misleading representation or advertising in the conduct of the business of insurance, or relative to the business of insurance.**	**RCW 48.30.040**

General Examination Standard 2: The Company was not able to produce one (1) requested provider agreement (OIC P076). The Company was not able to locate the application for one (1) underwriting file (OIC IF5).

The examiners experienced some difficulty in receiving an accurate list of Washington specific underwriting files from which to pull a sample. The Company initially provided a list of 408 groups; ultimately it was determined that the Company had 69 applicable groups. The initial list of 408 contracted groups was a compilation of data pulled from two systems which resulted in duplication of groups listed. In addition one system included all groups regardless of group situs or product line resulting in both Non-Washington groups as well as business from its affiliated Life Insurance Company being on the list.

General Examination Standard 4: The Company does not always do business in its own legal name so the entity being represented is not always clear. The examiners noted that the Company's national system for processing Explanation of Benefit or claim detail statements identifies the payor as Aetna Inc. and Affiliates, with the Aetna Inc. national logo. Aetna

Health, Inc., which is the licensed Washington HCSC, does not appear on Washington statements.

CLAIMS

Claims Procedures

Aetna Health Inc., provided the examiners with an outline of its claims procedures. The Company maintains its claims processing alerts, directives, policies and procedures as an online reference manual. This online manual was reviewed by the examiners while onsite and found to be comprehensive. The online claim policies and procedures are designed to ensure consistency in claim processing but do not necessarily reflect state specific adjudication requirements. Coordination of Benefits (COB) procedures provide examples for processors which call for a secondary carrier to provide reimbursements based solely on a primary carriers negotiated rate in violation of WAC 284-51-050(4).

Claims Processing

Medical claims are processed by the Company's HMO claims processing system. A second system platform is utilized for the adjudication of pharmacy claims and the Company contracts with Magellan Behavioral Health Systems for the adjudication of its behavioral health claims.

The Company has a National Quality Assessment Program in place which it terms the HMO QAP. The program is designed to identify errors, policies and processes contributing to inappropriate claim payments so as to identify quality improvement, trending and training opportunities. The program calls for audits for a random sample of one (1) to two (2) percent of all processor adjudicated claims as well as a randomly selected sample of one (1) percent of all auto-adjudicated claims. The Company auto adjudicates 70% of all claims.

Claims Review

The Company processed 171,694 Washington claims during the examination period. 149,123 or (87%) were large group claims and 22,571 or (13%) were small group claims. Pharmacy claims accounted for 43% of the total claims processed. A random sample of 100 claims was selected for review; the sample consisted of 55 medical and 45 pharmacy claims. A separate random sample of 25 claims involving coordination of benefits (COB) was also selected for review. During the review process the examiners discovered that five (5) of the selected claims involved federal members not under the jurisdiction of the OIC. This reduced the overall sample of claims reviewed from 125 to 120.

One (1) claim originally auto-adjudicated was identified during review to have been submitted listing an incorrect diagnosis code. The claim (OIC C-024) listed code V25.9 as opposed to V75.9. The listed procedure codes (90782, J1055 and 67800) were correct and the claim was

paid. The Company maintains it does have a system in place to identify claims in which there is an inconsistency between diagnosis and procedure codes however this claim submission did not trigger a rejection of the claim.

The following Claims Standards passed without comment:

#	Claims Standard	Reference
1	**The Company shall provide no less than urgent and emergency care to a child who does not reside in the Company's service area.**	**RCW 48.01.235(3)**
2	**All plans must provide female enrollees direct access to women's health care services.**	**RCW 48.42.100, WAC 284-43-250**
3	**All plans must include every category of provider.**	**RCW 48.43.045 WAC 284-43-205**
4	**All plans shall cover emergency services necessary to screen and stabilize a covered person.**	**RCW 48.43.093**
5	**Decisions concerning maternity care and services are to be made between the mother and the provider.**	**RCW 48.43.115**
6	**The Company shall not deny benefits for any service performed by a denturist if the service performed was within the lawful scope of such person's license, and the agreement would have provided benefits if services were performed by a dentist.**	**RCW 48.43.180, RCW 48.44.500**
7	**The Company maintains a documented utilization review program and conducts utilization review within the prescribed format defined.**	**RCW 48.43.520, WAC 284-43-410**
8	**The Company shall not retrospectively deny emergency or nonemergency care that had prior authorization.**	**RCW 48.43.525(1)**
9	**All plans must provide coverage for the formula necessary for the treatment of phenylketonuria (PKU).**	**RCW 48.44.440, WAC 284-44-450**
10	**The Company shall not retrospectively deny an individual prescription drug claim that had prior authorization.**	**RCW 48.44.465**
11	**The Company shall pay or deny claims subject to the required minimum standards. The Company pays interest on undenied and unpaid clean claims that are more than 6 days old.**	**WAC 284-43-321(2)**
12	**The denial of any claim must be communicated to the provider or facility with the specific reason claim denied.**	**WAC 284-43-321(4)**

The following Claims Standard failed:

#	Claims Standard	Reference
13	**The Company administers Coordination of Benefits provisions as required.**	**Chapter 284-51 WAC**

Claims Standard 13: In determining member responsibility as the secondary carrier under COB calculation procedures, the Company did not calculate its own allowed amount and instead determined member responsibility based on the contracted amount a provider may have had with the primary carrier. This is in violation of WAC 284-51-050(4).

WAC 284-51-050(7) specifies that a plan's COB savings shall be used to pay allowable expenses not otherwise paid, which are incurred during the claim determination period. Four (4) claims were identified in which COB savings were not calculated and added to the member's savings.

The Company received refunds from providers for two (2) claims that had initially been paid as primary carrier, but for which it was actually secondary. The provider refund did not include a statement of payment from the primary carrier which the Company required in order to determine the appropriate benefit. The Company did not attempt to contact the primary carrier for a statement of payment in those situations and did not use savings to pay those claims.

Two (2) COB claims involved processor input errors resulting in incorrect claim adjudication. One (1) COB claim was adjudicated incorrectly and the Company did not reimburse the member's liability.

See Appendix 1.

COMPLAINTS

Complaint Policies and Procedures

The Company provided the examiners with the following documents for review:

- Member Complaint and Appeal Definitions
- Post Service Appeal Procedure
- Pre-Service Appeal Procedure
- Aetna WA Member Complaint and Appeal Policy
- 2004 and 2005 Member Complaints and Appeal Policy
- 2004 and 2005 Member Complaint Procedure
- 2004 and 2005 Member Expedited Appeal Procedure
- 2004 and 2005 Member Complaint and Appeal – Authorized Representative Procedure

The procedures are comprehensive, detailed, and accurately describe the processes in place to handle oral and written complaints received directly by the Company and complaints received from the OIC.

Complaint Review

The Company's initial complaint database included 182 complaints. The list was found to have 14 duplicate entries so the total population from which samples were pulled was 168. The examiners reviewed the six (6) complaints received by the OIC which fell inside the scope of the examination period. An additional random sample of 44 complaints was selected from the Company's internal complaint database. A total of 50 complaint files were reviewed. No trends or issues were identified.

The following Complaint Standards passed without comment:

#	Complaints Standards	Reference
1	**The Company has filed a copy of its procedures for review and adjudication of complaints with the OIC.**	**RCW 48.43.055**
2	**The Company maintains a fully operational, comprehensive grievance process.**	**RCW 48.43.530, WAC 284-43-615**
3	**The Company provides enrollees access to independent review services to resolve disputes**	**RCW 48.43.535**
4	**Response to communications from the OIC must be within 15 business days of receipt of the correspondence. The response must contain the substantial information requested by the OIC.**	**WAC 284-30-650, Technical Advisory T 98-4**
5	**The Company complies with procedures for health care service review decisions.**	**WAC 284-43-620**

UNDERWRITING

Underwriting Manuals

The Company provided the examiners with copies of underwriting guidelines for all of its products as well as product specific underwriting rules. The guidelines and rules address in part the Company's policies for:

- Plan Availability Based On Location and Group Size
- Multi-Year Service Fee Guarantees
- Participation Requirements
- Employer Contribution Requirements
- Out of Area Coverage
- Eligibility
- Domestic Partners Coverage

The examiners noted that the Company's Washington Small Group Market Underwriting Guidelines, dated November 2001, reference a small group as being 1-50 eligible lives in

certain sections. Groups of one (1) do not fit Washington's small group criteria as defined in RCW 48.43.005(24) this is addressed under Standard Six.

The examiners found the guidelines and policies provided for review to be detailed and comprehensive.

Underwriting File Review

The examiners initially selected 100 files for review. During the examination process it was discovered that eleven of the selected groups were either no longer in-force during the exam period or not situsted in Washington. The following is a breakdown of the total population and random samples that were reviewed:

Type of Business	Total Population	Sample Selected
New Business	3	3
Inforce Business	66	36
Declined Business	642	50
Total	**711**	**89**

The declined business database consists of 36 Key Accounts which is the business segment the Company defines as plan sponsors with 301 to 3,000 eligible employees. The remaining 606 groups are Select Accounts which the Company identifies as plan sponsors with 51 to 300 eligible employees. The sample files reviewed show the primary reasons given for declining groups were:

- Ongoing medical claims.
- Company not competitive when compared to the in-force rates and plan design.

Findings

Underwriting standards 3, 4, 10, 11, 16 and 18 are not applicable to this examination as they apply only to coverage for individual policies which the Company does not write in Washington.

The following Underwriting Standards passed without comment:

1	**The Company complies with the prescribed requirements for enrollment and coverage of a child under the health plan of the child's parent.**	**RCW 48.01.235 (1)(2)(3)(4)**
2	**The Company appropriately reduces preexisting condition exclusions, limitations, or waiting periods in its large group, small group and individual plans by applying time covered by the preceding health plan coverage.**	**RCW 48.43.015 WAC 284-43-710**

	Underwriting Standard	Reference
5	**The Company may not reject an individual or deny, exclude or limit coverage in a small or large group based on preexisting conditions of the individual. The Company shall accept for enrollment any state resident within the group and within the carrier's service area.**	**RCW 48.43.025(1)(2) RCW 48.43.035 (1) WAC 284-43-720**
7	**Dependent children cannot be terminated from a group health plan because of developmental disability or physical handicap.**	**RCW 48.44.210**
8	**All plans shall cover newborn infants and congenital anomalies from the moment of birth.**	**RCW 48.44.212(1)**
9	**No plan shall deny coverage solely on account of race, religion, national origin, or the presence of any sensory, mental, or physical handicap.**	**RCW 48.44.220**
12	**All group plans shall offer coverage for chiropractic care on the same basis as any other care.**	**RCW 48.44.310(1)**
13	**All plans must include coverage for diabetes.**	**RCW 48.44.315**
14	**The Company may not refuse, cancel, or decline coverage solely because of a mastectomy or lumpectomy more than five (5) years prior.**	**RCW 48.44.335**
15	**Eligible group plans must offer optional supplemental coverage for mental health treatment for the insured and the insured's covered dependents. If mental health treatment is waived the contract holder has notified the Company, in writing, in advance of the waiver.**	**RCW 48.44.340(1) RCW 48.44.340(3) WAC 284-43-810**
17	**Adoptive children shall be covered on the same basis as other dependents.**	**RCW 48.44.420**
19	**All plans shall offer optional coverage for the treatment of temporomandibular joint disorders (TMJ) and maintain proof of offer as required.**	**RCW 48.44.460, WAC 284-44-042**
20	**The Company shall produce and provide certificates of coverage to the employer for distribution to each covered employee.**	**WAC 284-44-050**

The following Underwriting Standard passed with comment:

	Underwriting Standard	Reference
6	**Eligibility to purchase a health benefit plan must be extended to all small employers and small groups as defined in RCW 48.43.005(24).**	**RCW 48.43.028**

Underwriting Standard 6: The Company provided underwriting guidelines for the Washington Small Group Market which identifies the market as 1-50 eligible employees. The guidelines indicate that the Company has specific participation requirements for medical

underwriting for groups of 1-3 as well as for groups of 4-50. Employer contribution requirements are also set out specifically for groups of 1-50. To meet the small group definition under RCW 48.43.005(24) at least two (2) but no more than fifty eligible employees are required.

RATE AND FORM FILING

Rate and Form Filing Review

The Company provided a listing for all forms and contracts in use during the exam period. Rate filings and the rate manuals in use during the exam period were also provided for review.

The examiners used the random sample of 36 in-force and three (3) new groups selected for the underwriting portion of the exam as the sample for this section. Files were reviewed to ensure that the contract forms being used and the rates being billed were appropriately filed and approved.

Findings

Note: Standards 1 and 2 have a zero tolerance level.

The following Rate and Form Filing Standards passed without comment:

2	All rates have been filed with the Office of Insurance Commissioner prior to use.	RCW 48.44.040, WAC 284-43-920
3	All contract forms and rates have been filed with the Office of Insurance Commissioner on transmittal forms prescribed by and available from the Commissioner.	WAC 284-43-925

The following Rate and Form Filing Standard failed:

#	Rate and Form Filing Standards	Reference
1	All contract forms have been filed with the Office of Insurance Commissioner prior to use.	RCW 48.44.040, WAC 284-43-920

Rate and Form Filing Standard 1: The Company's filed and approved group agreement HCSC/WA SG GA-1 9/03 includes a definition for "Interested Parties" in section 1.6. The actual agreements issued to groups do not include the "Interested Parties" definition.

PROVIDER ACTIVITY

Provider Contracting Process

Network and Providers Services (NPS) is responsible for the Company's network of participating physicians, hospitals and health care providers. Within NPS, the Provider Data Services team maintains demographic and contractual data for all network providers.

Network Management is responsible for securing agreement from providers, hospitals, and provider groups to participate in Aetna plans. As part of its procedures the Company has developed standard guidelines to be followed when contracting with providers.

Provider Manuals

The Company provided the examiners with the following:

- Provider Manual – Aetna Benefit Products
- Administrative Procedures – Health Care Professional Toolkit
- Credentialing Procedures
  - Credentialing Allied Health Practitioners
  - Credentialing and Contract Assessment
  - Delegated Credentialing/Recredentialing
  - Practitioner Credentialing/Recredentialing

The manuals provided appeared to be complete and comprehensive.

Provider Activity Review

The Company provided the examiners with the Provider Directory in use during the examination period. The directory included specific sections listing Primary Care Providers, Specialists, Providers Speaking Additional Languages and Behavioral Health Providers. Participating hospitals and facilities were also listed. A random sample of 100 providers was selected for review. The Company was not able to locate one (1) selected contract (OIC P076). A total of 99 provider agreements were reviewed.

During review the examiners noted a significant delay in execution of the following two (2) contracts:

- P004 Agreement was signed by the Provider 12/19/1996 and was signed by the Company on 3/27/1998
- P008 Agreement was signed by the Provider 7/15/1997 and was signed by the Company on 3/27/1998

The Company could not determine the reason for the lag time between the providers signing of the contract and Aetna's signature on the contract. The market conduct examination adopted on 4/30/2003 noted an inadequate follow-up procedure with providers in regard to contract execution.

Contract negotiators have the ability to revise filed forms prior to contract issuance. One (1) contract (OIC P025) reviewed included an amendment from which the form number had been removed. The Company has determined that this was an isolated clerical error during the mailing preparation process. Two (2) contracts (P006 and P026) reviewed listed the initials of the contracting entity in the footer as opposed to the filed contract form number.

Subsequent event: The Company sent a communication to negotiators on 6/14/2007 advising them of the importance of leaving document footers intact.

A number of the contracts reviewed by the examiners contain a stipulation that each individual in a Provider Group contract directly with the Company. Physicians and other practitioners who are employees of medical groups are sometimes prohibited from signing individual agreements with HCSCs by their employers. However, the Company does not delete the clause requiring individual contracts when this is the case.

The Company contracts with several large clinics and provider groups, but does not contract with each provider in the clinic or group. They leave that function up to the actual Provider Group. However, the contract between the Company and the Provider Group (clinic) states that the Provider Group will hold each individual provider to the same standard as the Company requires of the Provider Group. RCW 48.43.550 requires that a Company must oversee any activities that it delegates to its subcontractor, in this case, the Provider Group. It does not appear that the Company is auditing the Provider Groups to ensure that there is oversight of the individual providers, and that terms of the agreement between the Company and the Provider Group are monitored or enforced.

Findings

The following Provider Activity Standards passed without comment:

2	**All plans must allow enrollees to select a primary care provider who is accepting new patients from a list of participating providers.**	**RCW 48.43.515 WAC 284-43-251**
3	**Provider contract forms contain language holding enrolled participant harmless should the Company fail to pay for health care services.**	**RCW 48.44.020(4) WAC 284-43-320(2)**
5	**Company standards for selection of participating providers and facilities does not result in risk avoidance or discrimination by excluding providers or facilities specializing in specific treatments or located in high risk geographic areas.**	**WAC 284-43-310(1)(a) and (b)**
6	**Providers have a mechanism for obtaining eligibility information from the Company.**	**WAC 284-43-320(1)**
8	**The Company does not preclude provider from informing**	**WAC 284-43-320(5)(a)**

	patient of care required and whether care is consistent with medical necessity, medical appropriateness or covered by plan.	
9	**The Company does not preclude or discourage providers from discussing merits of other carriers even if critical of the carrier.**	**WAC 284-43-320(5)(b)**
10	**The Company and provider shall provide at least 60 days written notice to each other before terminating contract without cause.**	**WAC 284-43-320(7)**

The following Provider Activity Standard passed with comment:

#	Provider Activity Standard	Reference
7	**The Company shall notify providers of their responsibilities regarding the Company's administrative policies and programs.**	**WAC 284-43-320(4)**

Provider Activity Standard 7: Company form WA/SB 1418 Provider Amendment (12.05) outlines timeframes for Company claims overpayment recovery and provider claims disputes. This amendment should have been sent to all applicable provider groups. The Company could not confirm that the amendment was sent to two (2) providers (OIC P029 and P099).

Subsequent Event: The Company sent the amendment to the providers on May 14, 2007.

The following Provider Activity Standards failed:

#	Provider Activity Standard	Reference
1	**Provider contracts shall contain procedures for the fair resolution of dispute arising out of the contract.**	**RCW 48.43.055 WAC 284-43-320(11) WAC 284-43-322**
4	**Provider contract forms must be filed and approved.**	**RCW 48.44.070 WAC 284-43-330**

Provider Activity Standard 1: Eleven of the provider agreements reviewed were agreements that had been filed and approved during or after 2004. These agreements contain the appropriate procedures for the fair resolution of disputes arising out of the contract. The remaining agreements in use do not outline that in the case of billing disputes, a carrier must render a decision within 60 days of the complaint. (WAC 284-43-322(5)) No amendatory endorsements to the originally signed agreements were found to address this requirement.

Provider Activity Standard 4: Three (3) instances were identified in which the Company did not use its most current filed and approved contract form. It is the OIC expectation that the Company withdraw and discontinue use of agreements that have been replaced.

- P018 Contract WA\Physician Group 6 (4/01) was signed by the Company 7/23/2003 and signed by the physician group on 7/7/2003. The Company's new agreement, WA\Physician Group Agreement 1 (8/02), was filed and approved for use effective 9/23/2002.

The Company uses the most current version of an agreement for its initial contract proposals to providers but it does not typically update the version of the agreement in the middle of a negotiation.

- P015 Contract WA\Provider Group 6 (4/01) was signed by the Company 8/13/2003 and signed by the provider group on 7/2/2003. The Company's new agreement, WA\Provider Group Agreement 1 (1/03), was filed and approved for use effective 5/5/2003.
- P025 Contract WA\Provider Group 6 (4/01) was signed by the Company 1/27/2004 and signed by the provider group 1/7/2004. The Company's new agreement, WA\Provider Group Agreement 1 (1/03), was filed and approved for use effective 5/5/2003.

Provider groups make copies of blank contracts and have new providers sign the agreement when they join the group. The signed agreements are sent to the Company. Upon receipt of signed contracts Company personnel are expected to verify that the document footers containing the form number matches the most current version of the filed provider contract. If the most current contract is not being used Aetna personnel are expected to contact the provider group and have the new provider sign a current contract form; this procedure step did not occur for the two (2) contracts noted above.

Contract negotiators routinely make changes to filed and approved template agreements. WAC 284-43-330(2) requires a health carrier to submit material changes to a sample contract form fifteen working days prior to use. The following are a few examples of changes the examiners determined to be material:

OIC P002 WA\Provider Group 5 (5\00)
- Section 1.3 The signed agreement deleted the requirement that each Participating Group Provider execute an individual agreement.
- Section 1.5 The filed template of the agreement requires the Group to provide the Company at least 120 days prior notice of the termination of Group's relationship with Participating Group provider. The signed agreement changes the notification requirement to 30 days.
- Section 5.1 The signed agreement reduced the required minimum amounts of professional liability insurance from the amounts stated in he filed contract of $5,000,000 per occurrence/$10,000,000 annual aggregate to $1,000,000 / $3,000,000 respectively.

OIC P010 WA\Physician Group 5 (5/00)
- Section 1.6.3 The signed agreement omits the following sentence found in the filed and approved template :

"To prevent discrimination against Company or its Members, for such time as such Primary Care Physicians office declines to accept new Members as patients, such office shall not accept as patients additional members from any other health maintenance organization."

- Section 3.1 The signed agreement adds the following to the payment section:
  "In such case, Company will take reasonable efforts to assist Group in collecting payment from Payor or Member, provided that Member is eligible at time of service. Company will not retrospectively deny coverage for eligible Member, for any pre-certified services on the grounds that such services were not Medically Necessary Services, unless subsequent review of the medical records disclose (a) the clinical findings prior to certification vary materially from the clinical findings communicated to Company or its affiliates, or (b) the plan of treatment varied from the plan certified by Company except in such cases as treatment was found to be immediately necessary during the course of the planned treatment by the treating physician."
- Section 3.2.3. The following paragraph was added to the agreement. It does not appear in the filed template agreement:
  "In the event that Company makes payment to Group for Covered Services provided to a Member, who is subsequently deemed to be ineligible, Company may request payment of overpayment from Group. Group may bill Member or other eligible payor for such services."
- Section 5.1 The filed agreement template sets out specific minimum professional and comprehensive general liability insurance amounts to be maintained by the Group. The agreement used does not include these minimum amounts; a general sentence has been added stating that relevant information regarding the amounts and extent of general and professional liability coverage will be disclosed to parties upon written request.
- Section 5.2 of the filed template outlines the group providers' insurance requirements; the agreement used deletes this requirement and replaces it with a requirement that the Company maintain appropriate amounts of general comprehensive liability and professional liability insurance.

The Company's procedures do not ensure that the agreements issued substantively reflect the agreements the Company has filed.

INSTRUCTIONS

#	Instruction	Page #
1	The examiners found multiple instances where the Company refers to itself both internally and externally as an HMO. The Company is instructed to immediately cease this practice and refer to itself as an HCSC in accordance with its Certificate of Registration. RCW 48.46.027(1)	9
2	The Company is instructed to audit all COB claims adjudicated within the last 12 months and attest to compliance with Chapter 284-51 WAC. Further it must develop procedures to ensure that Washington COB claims are adjudicated in accordance with Chapter 284-51 WAC.	12
3	The Company is instructed to properly file all forms with the OIC prior to use. RCW 48.44.040, WAC 284-43-920	17
4	The Company is instructed to add a provision to its dispute resolution procedure requiring the Company to render a decision within 60 days if a complaint involves a billing dispute and bring all current provider agreements into compliance. WAC 284-43-322(5).	20
5	The Company is instructed to file all substantive changes to its contract forms and bring all provider agreements into compliance. RCW 48.44.070, WAC 284-43-330.	20

RECOMMENDATIONS

#	Recommendation	Page #
1	It is recommended that the Company identify the correct Company name on all correspondence, explanation of benefits and any other statements going out to providers and members.	10
2	It is recommended that the Company facilitate future examinations by providing accurate, meaningful and complete information.	10
3	It is recommended that the Company update its underwriting guidelines to reflect the current Washington definition of a small group.	16
4	It is recommended that provider groups not be issued agreements that stipulate individual provider agreements if no individual agreements will be executed. The terms and conditions of the agreements used for specific groups, as well as individuals, should reflect actual operating procedures.	19
5	Currently, contracts with Provider Groups that consist of individual providers are sometimes issued in the name of the Provider Groups, and contracts with individual providers are not completed. The Company is allowing the Provider Groups to function as subcontractors, but is not	19

#	Recommendation	Page #
	auditing to ensure that all mandated provider activities and processes are being followed. It is recommended that the Company immediately implement subcontractor audits to ensure compliance with the appropriate code sections.	
6	It is recommended that the Company establish a procedure to ensure that all providers are properly notified of their responsibilities regarding the Company's administrative policies and programs.	20

SUMMARY OF STANDARDS

Company Operations and Management Standards:

#	STANDARD	PAGE	PASS	FAIL
1	The Company is required to be registered with the OIC prior to acting as a health care service contractor in the State of Washington. Reference: RCW 48.44.015(1).	8	X	
2	The Company is required to report to the OIC any changes to the registration documents, including Articles of Incorporation, Bylaws, and Amendments at the same time as submitting such documents to the Secretary of State. Reference: RCW 48.44.013.	9	X	
3	When the Company registers with the OIC, it is required to state its territory of operations. Reference: RCW 48.44.040.	9	X	
4	The Company shall not advertise or display its certificate of registration for use as an inducement in any solicitation. Reference: RCW 48.44.150.	9	X	
5	The Company is required to be registered with the Office of Insurance Commissioner prior to acting as a health maintenance organization in the State of Washington. Reference: RCW 48.46.027(1)	9		X

General Examination Standards:

#	STANDARD	PAGE	PASS	FAIL
1	The Company does business in good faith, and practices honesty and equity in all transactions. Reference: RCW 48.01.030.	10	X	
2	The Company must facilitate the examination process by providing its accounts, records, documents and files to the examiners upon request. Reference: RCW 48.44.145(2).	10	X	
3	The Company may not discourage members from contacting the OIC and may not discriminate against those members that do contact the OIC. Reference: WAC 284-30-572(2).	10	X	
4	No person shall knowingly make, publish, or disseminate any false, deceptive or misleading representation or advertising in the conduct of the business of insurance, or relative to the business of insurance. Reference: RCW 48.30.040	10	X	

Claims Standards:

#	STANDARD	PAGE	PASS	FAIL
1	The Company shall provide no less than urgent and emergent care to a child who does not reside in the company's service area. Reference: RCW 48.01.235(3).	12	X	

#	STANDARD	PAGE	PASS	FAIL
2	All plans must provide female enrollees direct access to women's health care services. Reference: RCW 48.42.100, WAC 284-43-250	12	X	
3	All plans must include every category of provider. Reference: RCW 48.43.045, WAC 284-43-205	12	X	
4	All plans shall cover emergency services necessary to screen and stabilize a covered person. Reference: RCW 48.43.093	12	X	
5	Decisions concerning maternity care and services are to be made between the mother and the provider. Reference: RCW 48.43.115	12	X	
6	The Company shall not deny benefits for any service performed by a denturist if the service performed was within the lawful scope of such person's license, and the agreement would have provided benefits if services were performed by a dentist. Reference: RCW 48.43.180, RCW 48.44.500.	12	X	
7	The Company maintains a documented utilization review program and conducts utilization review within the prescribed format defined. Reference: RCW 48.43.520, WAC 284-43-410	12	X	
8	The Company shall not retrospectively deny emergency or nonemergency care that had prior authorization. Reference: RCW 48.43.525(1)	12	X	
9	All plans must provide coverage for the formula necessary for the treatment of phenylketonuria (PKU). Reference: RCW 48.44.440, WAC 284-44-450	12	X	
10	The Company shall not retrospectively deny an individual prescription drug claim that had prior authorization. Reference: RCW 48.44.465	12	X	
11	The Company shall pay or deny claims subject to the required minimum standards. The Company pays interest on undenied and unpaid clean claims that are more than 61 days old. Reference: WAC 284-43-321(2).	12	X	
12	The denial of any claim must be communicated to the provider or facility with the specific reason the claim was denied. Reference: WAC 284-43-321(4).	12	X	
13	The Company administers Coordination of Benefits provisions as required. Reference: Chapter 284-51 WAC.	12		X

Complaint Standards:

#	STANDARD	PAGE	PASS	FAIL
1	The Company has filed a copy of its procedures for review and adjudication of complaints with the OIC. Reference: RCW 48.43.055	14	X	

#	STANDARD	PAGE	PASS	FAIL
2	The Company maintains a fully operational, comprehensive grievance process. Reference: RCW 48.43.530, WAC 284-43-615	14	X	
3	The Company provides enrollees access to independent review services to resolve disputes. Reference: RCW 48.43.535	14	X	
4	Response to communications from the OIC must be within 15 business days of receipt of the correspondence. The response must contain the substantial information requested by the OIC. Reference: WAC 284-30-650, Technical Advisory T 98-4	14	X	
5	The Company complies with procedures for health care service review decisions. Reference: WAC 284-43-620	14	X	

Underwriting Standards:

#	STANDARD	PAGE	PASS	FAIL
1	The Company complies with the prescribed requirements for enrollment and coverage of a child under the health plan of the child's parent. Reference: RCW 48.01.235.	15	X	
2	The Company appropriately reduces preexisting condition exclusions, limitations, or waiting periods in its large group, small group and individual plans by applying time covered by the preceding health plan coverage. Reference: RCW 48.43.015 WAC 284-43-710	15	X	
3	An individual is not required to complete the standard health questionnaire if stated criteria are met. Reference: RCW 48.43.018(1)	N/A		
4	The Company shall provide written notice of its decision not to accept an individual's application for enrollment to both the applicant and WSHIP within 15 business days of receipt of a completed application. Reference: RCW 48.43.018(2)(b), WAC 284-91-060(2)	N/A		
5	The Company may not reject an individual for health plan coverage in a large or small group based upon preexisting conditions of the individual. The Company may not deny, exclude, or limit coverage for an individual's preexisting health conditions. The Company shall accept any state resident within the group and within the Company's service area. Reference: RCW 48.43.025, RCW 48.43.035(1), WAC 284-43-720	16	X	
6	Eligibility to purchase a health benefit plan must be extended to all small employers and small group as defined in RCW 48.43.005(24). Reference: RCW 48.43.028	16	X	

#	STANDARD	PAGE	PASS	FAIL
7	Dependent children cannot be terminated from an individual or group plan because of developmental disability or physical handicap. Reference: RCW 48.44.200, RCW 48.44.210.	16	X	
8	All plans shall cover newborn infants and congenital anomalies from the moment of birth. Reference: RCW 48.44.212(1).	16	X	
9	No plan shall deny coverage solely on account of race, religion, national origin, or the presence of any sensory, mental, or physical handicap. Reference: RCW 48.44.220.	16	X	
10	An individual may return an individual health care contract for a full refund within ten (10) days of its delivery if not satisfied with the contract for any reason. Reference: RW 48.44.230	N/A		
11	All cancellations, denials, or non-renewals of an individual plan must be in writing and include the reason for such action. Reference: RCW 48.44.260	N/A		
12	All group plans shall offer coverage for chiropractic care on the same basis as any other care. Reference: RCW 48.44.310	16	X	
13	All plans must include coverage for diabetes. Reference: RCW 48.44.315	16	X	
14	The Company may not refuse, cancel, or decline coverage solely because of a mastectomy or lumpectomy more than five (5) years prior. Reference: RCW 48.44.335	16	X	
15	Eligible group plans must offer optional supplemental coverage for mental health treatment for the insured and the insured's covered dependents. If mental health treatment is waived the contract holder has notified the Company, in writing, in advance of the waiver. Reference: RCW 48.44.340(1), (3) and WAC 284-43-810	16	X	
16	Dependents shall have the right to continue coverage in the event of loss of eligibility by the principal enrollee. Reference: RCW 48.44.400.	N/A		
17	Adoptive children shall be covered on the same basis as other dependents. Reference: RCW 48.44.420.	16	X	
18	A rider will be cancelled upon application by the enrollee if, at least five (5) years after its issuance, no health care services have been received by the enrollee for the condition specified in the rider. Reference: RCW 48.44.430	N/A		
19	All plans shall offer optional coverage for the treatment of temporomandibular joint disorders (TMJ) and maintain proof of offer as required. Reference: RCW 48.44.460, WAC 284-44-042.	16	X	

#	STANDARD	PAGE	PASS	FAIL
20	The Company shall produce and provide certificates of coverage to the employer for distribution to each covered employee. Reference: WAC 284-44-050	16	X	

Rate and Form Filing Standards:

#	STANDARD	PAGE	PASS	FAIL
1	All contract forms have been filed with and approved by the OIC prior to use. Reference: RCW 48.44.040, WAC 284-43-920.	17		X
2	All rates have been filed with the OIC prior to use. Reference: RCW 48.44.040, WAC 284-43-920.	17	X	
3	All contract forms and rates have been filed with the OIC on transmittal forms prescribed by and available from the Commissioner. Reference: WAC 284-43-925.	17	X	

Provider Activity Standards:

#	STANDARD	PAGE	PASS	FAIL
1	All provider contract forms shall contain procedures for the fair resolution of disputes arising out of the contract. Reference: RCW 48.43.055, WAC 284-43-320(11), WAC 284-43-322	20		X
2	All plans must allow enrollees to select a primary care provider who is accepting new patients from a list of participating providers. Reference: RCW 48.43.515, WAC 284-43-251.	19	X	
3	All provider contracts shall contain language holding the enrolled participant harmless should the Company fail to pay for health care services. Reference: RCW 48.44.020(4) WAC 284-43-320(2)	19	X	
4	All provider contract forms must be filed with and approved by the OIC prior to use. Reference: RCW 48.44.070, WAC 284-43-330.	20		X
5	Company standards for selection of participating providers and facilities do not result in risk avoidance or discrimination by excluding providers or facilities specializing in specific treatments or located in high risk geographic areas. Reference: WAC 284-43-310(1)(a) and (b).	19	X	
6	The Company establishes a mechanism by which its participating providers can obtain eligibility and benefits information. Reference: WAC 284-43-320(1)	19	X	
7	The Company notifies all providers of their responsibilities regarding the Company's administrative policies and programs. Reference: WAC 284-43-320(4)	20	X	

#	STANDARD	PAGE	PASS	FAIL
8	The Company does not preclude the provider from informing the patient of care required and whether such case is consistent with medical necessity, medical appropriateness, or covered by the plan. Reference: WAC 284-43-320(5)(a)	19	X	
9	The Company does not preclude or discourage providers from discussing the merits of other carriers even if critical of a carrier. Reference: WAC 284-43-320(5)(b)	20	X	
10	The Company and the provider will provide at least 60 days written notice to each other before terminating the contract without cause. Reference: WAC 284-43-320(7)	20	X	

APPENDIX 1

Claims Standard 13: The Company administers Coordination of Benefits provisions as required. Reference: Chapter 284-51 WAC

OIC #	Claim #	Comment
CB 01	31007862549	The processor did not accurately capture the amounts reflected on the Medicare EOB when entering the information into Aetna's system.
CB 02	04126E12260	Company initially paid as primary. Provider sent a refund which included the primary carrier's statement of payment. A manual adjustment to the accumulator should have been performed but was not.
CB 04	041027E06799	Company initially paid as primary. Provider sent a refund but did not include the primary carrier's statement of payment which the Company requires so COB was not applied.
CB 05	051101K11063	Company initially paid as primary. Provider sent a refund which included the primary carrier's statement of payment. A manual adjustment to the accumulator should have been performed but was not.
CB 06	50331008232	Company initially paid as primary. Provider sent a refund but did not include the primary carrier's statement of payment which the Company requires so COB was not applied.
CB 11	509130080735	Company initially paid as primary. Provider sent a refund which included the primary carrier's statement of payment. A manual adjustment to the accumulator should have been performed but was not.
CB19	050716E58736	Company initially paid as primary. Provider sent a refund which included the primary carrier's statement of payment. A manual adjustment to the accumulator should have been performed but was not.
CB 20	060414C37085	As a result of processor input error the primary's allowable expense was entered as $439.43, it should have reflected an amount of $150.16.

Aetna
2625 Shadelands Drive
Walnut Creek, CA 94598

Reina Galanes
Regional Compliance Director
Law & Regulatory Affairs, F915
(510) 522-6432
Fax: (860) 754-1920

November 27, 2007

James T. Odiorne, CPA, JD
Deputy Insurance Commissioner
Company Supervision Division
Office of Insurance Commissioner
5000 Capitol Blvd.
Tumwater, WA 98501

Re: Response to Preliminary Report of the Market Conduct Examination of Aetna Health Inc. (NAIC #47060)

Dear Mr. Odiorne,

Aetna Health Inc. (the Company) is in receipt of the Office's Preliminary Report of the Market Conduct Examination issued on November 1, 2007 and received on November 5, 2007. We are committed to continually improving the quality of service we provide to our members, providers and customers, and appreciate the feedback provided in this report. Please find below responses to the standards listed as "failed" in the report, including a description of corrective actions, for each alleged violation cited and identified by section in the report. The standards are noted below in italics, followed by the Company's response.

Company Operations and Management
Standard 5 (RCW § 48.46.027(1))
The Company is required to be registered with the Office of Insurance Commissioner prior to acting as a health maintenance organization in the State of Washington.

Company's Response
The Company respectfully disagrees with this finding, which concerns references in certain situations to "HMO" as opposed to Health Care Service Contractor (HCSC). The examiner noted references to "HMO" in Board Meeting minutes, responses to member complaints, in the Company's claim system and in a response from the Company to the examiner on its claim procedure manuals. Regarding member complaints, the Company uses Aetna Health Inc. on member complaint letters as the legal entity providing coverage, which is the entity registered with the Office of Insurance Commissioner as an HCSC. Regarding Board Meeting minutes, the claim system and the response to the

examiner on claim procedure manuals, these are internal, proprietary documents. External communications to members are properly labeled. Therefore, the Company requests that this finding be removed from the Final Report.

Claims

Standard 13 (Chapter 284-51 WAC)
The Company administers Coordination of Benefits provisions as required.

Company's Response

Effective July 9, 2007, the Company has implemented Insurance Commissioner Matter Number R 2005-7, which establishes new rules regarding Coordination of Benefits. Specifically, these new rules repeal WAC 284-51-010 through 28-51-185 (the subject of this examination) and replace them with WAC 284-51-190 through 284-51-260. The Company attests that its implementation of these new rules during the pendency of this examination meets the requirements of WAC 284-51.

Rate and Form Filing

Standard 1 (RCW 48.44.040, WAC 284-43-920)
All contract forms have been filed with the Office of Insurance Commissioner prior to use.

Company's Response

The Company respectfully disagrees with the facts of this finding with regard to the premium grace period. The referenced form (HCSC/WA SG GA-1 9/03) was filed and approved in 2004. Please note that this filing allowed for variable language pertaining to the grace period for past due premiums (Section 3.2). Enclosed are the filed form and the cover letter for the filing which explained the variable language. As the cited form was filed as required, the Company requests that this part of the finding be removed from the Final Report. The Company is uploading the definition of Interested Parties into the Group Agreement, as filed.

Provider Activity

Standard 1 (RCW 48.43.055, WAC 284-43-320(11), WAC 284-43-322)
Provider contracts shall contain procedures for the fair resolution of disputes arising out of contract.

Company's Response

The Company notes that prior to the issuance of the Preliminary Report, the Company had filed updated provider contracts with the Office to address its concerns regarding the fair resolution of disputes arising out of the contract. The Company's most recent submission was filed on October 29, 2007, in response to the Office's comments in its letter dated September 4, 2007. The Company awaits the Office's approval of this filing. Additionally the Company would like to note that its provider appeals process specifies that all types of provider disputes are to be resolved within 30 days.

Provider Activity
Standard 4 (RCW 48.44.070, WAC 284-43-330)
Provider contract forms must be filed and approved.

Company's Response
The Preliminary Report describes two types of issues as being in violation of the cited statute and regulation. Specifically, the Office indicates that:

- "Three (3) instances were identified in which the Company did not use its most current filed and approved contract form. It is the OIC expectation that the Company withdraw and discontinue use of agreements that have been replaced...The Company uses the most current version of an agreement for its initial contract proposals to providers, but it does not typically update the version of the agreement in the middle of a negotiation."
- "Contract negotiators routinely make changes to filed and approved template agreements. WAC 284-43-330(2) requires a health carrier to submit material changes to a sample contract form fifteen working days prior to use. The following are a few examples of changes the examiners determined to be material..."

The Company respectfully disagrees with the finding for the following reasons:

1) Neither the statute nor the regulation stipulates that carriers must withdraw and discontinue use of agreements that have been replaced. The Company is continually negotiating new agreements with its providers. It would be a burden to both the Company and the provider, if they had to move to a newly approved form of agreement once negotiations have already begun.

   The Company believes that Section 9.1 of its provider contract satisfactorily addresses provider notification of changes in the contract that are required by law or regulations, as follows:

   - 9.1 This Agreement constitutes the entire understanding of the Parties hereto and no changes, amendments or alterations shall be effective unless signed by both Parties, except as expressly provided herein. Notwithstanding the foregoing, at Company's discretion, Company may amend this Agreement upon written notice, by letter, newsletter, electronic mail or other media, to comply with applicable law or regulation, or any order or directive of any governmental agency.

2) Neither the statute nor the regulation defines the term "material change" as applied to business negotiations between an HCSC and a provider. In the Preliminary Report, the examples of changes that the examiners considered to be material were all made at the request of providers and to accommodate provider's specific situations. The Company does not consider these types of changes to be material.

As the Company amends provider contracts when changes are required by law or regulation, and the contract changes noted in the exam were made at the request of the provider and we do not consider the changes to be material, the Company requests that this finding be removed from the Final Report.

Thank you for the opportunity to present this response to the Office's Preliminary Report. Based upon the preceding substantive responses, the Company would respectfully request that the final Report of Examination be amended accordingly.

Sincerely,

Reina Galanes, Ph.D.
West Region Compliance Director

cc: Michael G. Watson, Chief Deputy Insurance Commissioner
Leslie Krier, Market Conduct Oversight Manager
Sandy Ray, Examiner-in Charge

April 7, 2004

TO: OFFICE OF INSURANCE COMMISSIONER
HEALTH CARE DIVISION
PO BOX 40255
OLYMPIA, WA 98504-0255

FROM: Aetna Health Inc.
413 Pine Street, MS F979
Seattle, Washington 98101
CONTACT PERSON: Martia Frewen, Compliance Consultant
CONTACT PHONE: 206-701-1084

SUBJECT 18 Month Forms Filing for New Legal Entity
ATTENTION Jennifer Kreitler and Linda Broyles

The above-referenced 18 month filing for the merged legal entity Aetna Health Inc. (Aetna). is submitted for your review and approval. Included for reference are copies of the e-mail (dated February 4, 2004) documenting the conference calls between the Office of the Insurance Commissioner (OIC) and Aetna discussing the effect of the 12/31/03 legal entity merger on our outstanding submissions. This 18 month filing includes new plan documents supporting the plan designs (Primary Choice, QPOS, USAccess) offered to large groups by Aetna Health Inc. Primary Choice is the new name for the plan designs formerly offered under the Health Maintenance Organization license which has been merged into the former Aetna Health of Washington Inc..

In June of 2001, Aetna and the Office of the Insurance Commissioner reached an agreement that allowed Aetna to file additional variability in their forms provided, that 1) Aetna provide an explanation of all variability, 2) Aetna provide sample ("test) documents which illustrate how actual member documents look, and 3) Aetna provide documentation of compliance with all mandates. The organization of the filing submitted below is designed to meet these requirements and facilitate your review.

The following documents are enclosed in this filing:

- A copy of the February 4, 2004 e-mail from Jennifer Kreitler
- Filing Face Sheet Large Group 18 month filings for Primary Choice and QPOS/USAccess Plan Designs.
- Compliance Charts identifying page numbers for verifying compliance with Washington laws and regulations as listed on the Analyst's Worksheet.
- Clean Copies of all forms with Explanations of Variability. Note that for ease of review of the Prescription Drug Rider, we have included the attachments supplied with the previous submission on 8/26/03. (Green Separator Pages
- Sample ("test") Documents (Blue Separator Pages)
- Redline documents showing changes from previous 18 month filing, including incorporation of all endorsements and amendments. (Yellow Separator Pages)
- A copy of this letter and the filing face sheets accompanied by a postage paid, self addressed envelope for your convenience in acknowledging this filing.

Included in the Clean Copy Filed Forms with Explanation of Variability, is the Employer Application Form. As you recall, this form was disapproved because it contained variable language not listed in the OIC's General Filing Instructions, and it referenced products sold by other Aetna Inc. subsidiaries. We have removed the variable language from the Employer Application. Aetna respectfully requests that the OIC consider allowing us to use this

All Products Employer Application with references to other entities doing business in Washington for the following reasons:

- With the legal entity names not applicable to Washington removed, the form clearly discloses the name of the company offering each type of coverage in Washington.
- This form has been filed for use with Aetna Life Insurance Company in Washington, and was not found objectionable.
- Employer groups prefer the convenience of one application for multiple types of coverage. It is extra work for them to have to provide identical information in order to purchase multiple types of coverage.
- Our internal operating systems are designed to input data using this form, and creating state-specific separate forms for coverage provided by Aetna Life Insurance Company adds to our administrative expense, without providing any corresponding benefit to the Employer or employees.

We appreciate your willingness to consider our wish to use this form.

I would welcome the opportunity to answer any questions or supply additional information which you might need. I can be reached at the contact number listed above or by e-mail at frewenm@aetna.com.

[AETNA HEALTH INC.]
(WASHINGTON)

GROUP AGREEMENT COVER SHEET

Contract Holder:	[Group Name]
Contract Holder Number:	[Group No.] [Locations/Eligibility Class] [Service Areas]
[**HCSC [Primary Choice**]Referred Benefit Level :	[Product Name] Benefits Package]
[QPOS® Non-Referred Benefit Level:	[Plan Name] Benefits Package]
[USAccess® Non-Referred Benefit Level:]	[Plan Name] Benefits Package]
Effective Date:	12:01 a.m. on [Effective Date]
Term of **Group Agreement**:	The **Initial Term** shall be: From [ ] through [ ] Thereafter, **Subsequent Terms** shall be: From [ ] through [ ]
Premium Due Dates:	The **Group Agreement Effective Date** and the [1st,15th] day of each succeeding calendar month.
Governing Law:	Federal law and the laws of Washington
Notice Address for **HCSC**:	[1425 Union Meeting Road Post Office Box 1445 Blue Bell, PA 19422]

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

[AETNA HEALTH INC.]

By: _____
[Name]
[Title]

Contract Holder Name: [ ]
Contract Holder Number: [ ]
Contract Holder Locations: [ ]
Contract Holder Service Areas: [ ]
Contract Holder Group Agreement Effective Date: [ ]

FORM: [ ]

[AETNA HEALTH INC.]
(WASHINGTON)

GROUP AGREEMENT

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

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

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

SECTION 1. DEFINITIONS

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

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

1.2 The terms " **HCSC", "Us", "We"** or **"Our"** mean [Aetna Health Inc.].

1.3 **"Certificate"** means the Certificate of Coverage issued pursuant to this **Group Agreement**.

1.4 **"Grace Period"** is defined in Section 3.2.

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

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

1.7 **"Party, Parties"** means **HCSC** and **Contract Holder**.

1.8 **"Premium(s)"** is defined in Section 3.1.

1.9 **"Renewal Date"** means the first day following the end of the **Initial Term** or any **Subsequent Term**.

1.10 **"Term"** means the **Initial Term** or any **Subsequent Term**.

1.11 Capitalized and bolded terms not defined in this **Group Agreement** shall have the meaning set forth in the **Certificate**.

SECTION 2. COVERAGE

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

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

SECTION 3. PREMIUMS

3.1 **Premiums.** **Contract Holder** shall pay **Us** on or before each **Premium Due Date** a monthly advance premium (the **"Premium"**) determined in accordance with the **Premium** rates and the manner of calculating **Premiums** specified by **HCSC**. **Premium** rates and the manner of calculating **Premiums** may be adjusted in accordance with Section 3.4 below. **Premiums** are subject to adjustment, if any, for partial month participation as specified in Section 3.3 below. Membership as of each **Premium Due Date** will be determined by **Us** in accordance with **Our Member** records. A check does not constitute payment until it is honored by a bank. **We** may return a check issued against insufficient funds without making a second deposit attempt. **We** may accept a partial payment of **Premium** without waiving our right to collect the entire amount due.

3.2 **Past Due Premiums.** If all **Premiums** are not received before the end of a [10-120] day grace period (the **"Grace Period"),** this **Group Agreement** [will be automatically terminated] [may be terminated by **Us**] pursuant to Section 6.3 hereof.

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

3.[3] **Prorations.** [**Premiums** shall be paid in full for **Members** whose coverage is in effect on the **Premium Due Date** [or whose coverage terminates on the last day of the **Premium** period].]

[**Premiums** for **Members** whose coverage is effective on a day other than the first day of the billing month or whose coverage terminates on a day other than the last day of the billing month shall be adjusted as indicated below:

[[Alternative #1:]

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

[• If membership terminates between the [1st through the 15th] [16th through the 31st] of the month, no **Premium** is due for that month. If membership terminates between the [16th through the 31st] [1st through the 15th] of the month, the **Premium** for the whole month is due.]]

[[Alternative #2:]

[• If membership becomes effective on any day other than the **Premium Due Date**, one-half the monthly **Premium** is due. If membership becomes effective on a **Premium Due Date**, the **Premium** for the whole month is due.]

[• If membership terminates on the **Premium Due Date**, no **Premium** is due for that month. If membership terminates on a date other than the **Premium Due Date**, one-half the monthly **Premium** is due.]]

[[Alternative #3:]
[• If membership becomes effective on the first of the month, the **Premium** for the whole month is due. If membership becomes effective after the first of the month, no **Premium** is due for the first month of membership.]

[• If membership terminates on the first of the month, no **Premium** is due for that month. If membership terminates after the first of the month, the **Premium** for the whole month is due.]]

[[Alternative #4:]
[• Billing will begin the day of eligibility on a pro-rata basis. The formula for pro-rata billing is: one month's full **Premium** multiplied by 12 (months in a year), then divided by 365 (days in a year) to achieve a daily rate which is then multiplied by the number of days the **Member** is actually enrolled during the first month.]

[• **Member** termination is effective on the actual date of termination and **Premium** is due on a pro-rata basis for each day the **Member** is active in the final month of membership. The formula for pro-rata computation is: one month's full **Premium** multiplied by 12 (months in a year), then divided by 365 (days in a year) to achieve a daily rate which is then multiplied by the number of days the **Member** was eligible during the month.]]]

3.4 **Changes in Premium.** **We** may also adjust the **Premium** rates and/or the manner of calculating **Premiums** effective as of any **Premium Due Date** upon [30-120] days prior written notice to **Contract Holder**, provided that no such adjustment will be made during the **Initial Term** except to reflect changes in applicable law or regulation or a judicial decision having a material impact on the cost of providing **Covered Benefits** to **Members**.

[At the end of a **Term**, **We** may declare an experience credit. The amount of each credit **We** declare will be returned to **Contract Holder**. Upon the request of the **Contract Holder**, part or all of it will be applied against the payment of **Premium** or in any other manner as may be agreed to by the **Contract Holder** and **Us**. If the sum of **Subscriber** contributions exceed the sum of **Premiums** (after applying any experience credits), the excess will be used by the **Contract Holder** for the sole benefit of the **Subscribers**. The **Contract Holder** is solely responsible for the distribution of such excess.]

3.[5] **Membership Adjustments.** **We** may, at **Our** discretion, make retroactive adjustments to the **Contract Holder's** billings for the termination of **Members** not posted to previous billings. However, **Contract Holder** may only receive a maximum of [1-3] [billing period['s]] [calendar month['s]] credit for **Member** terminations that occurred more than [30-90] days before the date **Contract Holder** notified **Us** of the termination. **We** may reduce any such credits by the amount of any payments **We** may have made on behalf of such **Members** (including capitation payments and other claim payments) before **We** were informed their coverage had been terminated. Retroactive additions will be made at **Our** discretion based upon eligibility guidelines, as set forth in the **Certificate**, and are subject to the payment of all applicable **Premiums**.

SECTION 4. ENROLLMENT

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

- at least once during every twelve month period during the **Open Enrollment Period**; and

- within [31-180] days from the date the individual and any dependent becomes eligible for coverage.

Eligible individuals and dependents who are not enrolled within the **Open Enrollment Period** or [31-180] days of becoming eligible, may be enrolled during any subsequent **Open Enrollment Period**. Coverage will not become effective until confirmed by **Us**. **Contract Holder** agrees to hold the **Open Enrollment Period** consistent with the **Open Enrollment Period** applicable to any other group health benefit plan being offered by the **Contract Holder** and in compliance with applicable law. The **Contract Holder** shall permit **Our** representatives to meet with eligible individuals during the **Open Enrollment Period** unless the parties agree upon an alternate enrollment procedure. As described in the **Certificate**, other enrollment periods may apply.

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

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

SECTION 5. RESPONSIBILITIES OF THE CONTRACT HOLDER

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

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

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

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

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

We will not be liable to **Members** for the fulfillment of any obligation prior to information being received in a form satisfactory to **Us**. **Contract Holder** must notify **Us** of the date in which a **Subscriber's** employment ceases for the purpose of termination of coverage under this **Group Agreement**. Subject to

applicable law, unless otherwise specifically agreed to in writing, **We** will consider **Subscriber's** employment to continue until the earlier of:

- until stopped by the **Contract Holder**;
- if **Subscriber** has stopped working due to temporary lay off or leave of absence (except where State or Federal law (such as the Federal Medical Leave Act) requires that coverage be continued), not beyond the end of the policy month after the policy month in which the absence started; and
- if **Subscriber** stopped working due to disability, not beyond the end of the 30th policy month after the month in which the absence started.

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

5.3 **Forms.** Distribute materials to **HCSC Members** regarding enrollment, health plan features, including **Covered Benefits** and exclusions and limitations of coverage. **Contract Holder** shall, within [10-31] [business] days of receipt from an eligible individual, forward all completed enrollment information and other required information to **Us**.

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

5.5 **Continuation Rights and Conversion.** Notify all eligible **Members** of their right to continue or convert coverage pursuant to applicable law.

5.6 **ERISA Requirements.** Maintain responsibility for making reports and disclosures required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), including the creation, distribution and final content of summary plan descriptions, summary of material modifications and summary annual reports.

SECTION 6. TERMINATION

6.1 **Termination by Contract Holder**. This **Group Agreement** may be terminated by **Contract Holder** as of any **Premium Due Date** by providing **Us** with [30-180] days prior written notice. However, **We** may in **Our** discretion accept an oral indication by **Contract Holder** or it's agent or broker of intent to terminate.

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

6.3 **Termination by Us.** This **Group Agreement** will terminate [as of the last day of the **Grace Period**][immediately upon notice to **Contract Holder**] if the **Premium** remains unpaid at the end of the **Grace Period**.

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

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

- Immediately upon notice to **Contract Holder** if **Contract Holder** no longer has any enrollee under the Plan who resides [or works] in the **Service Area**;

- Upon [30-180] days written notice to **Contract Holder** if **Contract Holder** (i) breaches a provision of this **Group Agreement** and such breach remains uncured at the end of the notice period; (ii) ceases to meet **Our** requirements for an employer group[or association]; (iii) fails to meet **Our** contribution or participation requirements applicable to this **Group Agreement** (which contribution and participation requirements are available upon request); (iv) fails to provide the certification required by Section 5.4 within a reasonable period of time specified by **Us**; or (v) changes its eligibility or participation requirements without **Our** consent;

- Upon 90 days written notice to **Contract Holder** (or such shorter notice as may be permitted by applicable law, but in no event less than [30-60] days) if **We** cease to offer the product to which the **Group Agreement** relates;

- Upon 180 days written notice to **Contract Holder** (or such shorter notice as may be permitted by applicable law, but in no event less than [30-120] days) if **We** cease to offer coverage in a market in which **Members** covered under this **Group Agreement** reside;

- Upon 30 days written notice to **Contract Holder** for any other reason which is acceptable to the Office of the Insurance Commissioner and consistent with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or by applicable federal rules and regulations, as amended[; or

- Immediately upon notice to **Contract Holder** if **Contract Holder's** membership in the association ceases].

6.4 **Effect of Termination.** No termination of this **Group Agreement** will relieve either party from any obligation incurred before the date of termination. When terminated, this **Group Agreement** and all coverage provided hereunder will end at 12:00 midnight on the effective date of termination. Upon termination, **We** will provide **Members** with Certificates of Creditable Coverage which will show evidence of a **Member's** prior health coverage with **Us** for a period of up to 18 months prior to the loss of coverage.

6.5 **Notice to Subscribers and Members**. It is the responsibility of **Contract Holder** to notify the **Members** of the termination of the **Group Agreement** in compliance with all applicable laws. However, **We** reserve the right to notify **Members** of termination of the **Group Agreement** for any reason, including non-payment of **Premium**. In accordance with the **Certificate**, the **Contract Holder** shall provide written notice to **Members** of their rights upon termination of coverage.

SECTION 7. PRIVACY OF INFORMATION

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

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

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

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

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

SECTION 8. INDEPENDENT CONTRACTOR RELATIONSHIPS[; INDEMNIFICATION]

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

Participating Providers are responsible for any health services rendered to their **Member** patients. **We** make no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any **Physician**, **Hospital** or other **Participating Provider**. A **Provider's** participation may be terminated at any time without advance notice to the **Contract Holder** or **Members**, subject to applicable law. **Participating Providers** provide health care diagnosis, treatment and services for **Members**. **We** administer and determine plan benefits. In Compliance with Washington law, RCW 48.43.545(1)(a)), **We** adhere to the same accepted standard of care for health care providers under RCW 7.70 when arranging for the provision of **Medically Necessary** health care services to **Members**.

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

[8.3 **Indemnification**. The **Parties** agree that **Contract Holder's** employee benefit plan is a "plan" within the meaning of Section 3 (3) of ERISA, unless specifically exempt thereunder. Generally, ERISA preempts all non-insurance state laws insofar as they relate to an employee benefit plan covered by ERISA. Therefore, there should be no liability by **Us** or **Contract Holder** to third parties pursuant to state law that arises out of this **Group Agreement**, **Our** performance hereunder, or **Contract Holder's** role as employer or Plan Sponsor.

[However, in order to fully define their indemnity obligations (a) in light of the possibility of a change in law affecting ERISA preemption of state law and (b) in the case of an action under ERISA, the **Parties** agree to the following:

- **We** shall indemnify and hold harmless **Contract Holder** for that portion of any liability, settlement and related expense (including the cost of legal defense) which was caused solely, directly and independently of all other causes by **Our** fraud, willful misconduct, criminal misconduct, or material breach of this **Group Agreement**.

- **Contract Holder** shall indemnify and hold harmless **Us**, **Our** affiliates and their respective directors, officers, eligible individuals or agents, for that portion of any liability, settlement and related expense (including the cost of legal defense) which was caused by **Contract Holder's** negligence, breach of this **Group Agreement**, breach of applicable state and federal laws, willful misconduct, criminal conduct, fraud, or its breach of a fiduciary responsibility in the case of an action under ERISA, related to or arising out of this **Group Agreement** or **Contract Holder's** role as employer or Plan Sponsor, as defined by ERISA.

The party seeking indemnification under the first or second bullet above must notify the indemnifying party promptly in writing of any actual or threatened action, suit or proceeding to which it claims such indemnity

applies. Failure promptly to so notify the indemnifying party shall be deemed a waiver of the right to seek indemnification.

The **Parties** agree that neither is responsible for patient care and related treatment decisions which are the sole responsibility of health care **Providers**, that health care **Providers** are not the agents of either, and that in no event shall the indemnity obligations under the first or second bullet above apply to that portion of any liability, settlement and related expense caused by the acts or omissions of health care **Providers** with respect to **Members**.

The **Parties** agree that in no event shall the indemnity obligations under the first or second bullet above apply to that portion of any liability, settlement and related expense caused by (a) **Our** act or omission undertaken at the direction of **Contract Holder** or **Contract Holder's** agent; or (b) **Contract Holder's** act or omission undertaken at **Our** expressed written direction.

The indemnification obligations of the **Parties** shall terminate upon the expiration of this contract except as to any matter concerning a claim which has been asserted by notice to the other **Party** at the time of such expiration or within 365 days thereafter.]]

SECTION 9. MISCELLANEOUS

9.1 **Delegation and Subcontracting.** **Contract Holder** acknowledges and agrees that **We** may enter into arrangements with third parties to delegate functions hereunder such as utilization management, quality assurance and provider credentialing, as **We** deem appropriate in **Our** sole discretion and as consistent with applicable laws and regulations. **Contract Holder** also acknowledges that **Our** arrangements with third party vendors (i.e. pharmacy, behavioral health) are subject to change in accordance with applicable laws and regulations.

9.2 **Accreditation and Qualification Status**. **We** may from time to time obtain voluntary accreditation or qualification status from a private accreditation organization or government agency. **We** make no express or implied warranty about **Our** continued qualification or accreditation status.

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

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

- This **Group Agreement** shall be deemed to be automatically amended to conform with all rules and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over **Us**;
- By written agreement between both **Parties**; or
- By **Us** upon [30-120] days written notice to **Contract Holder**.

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

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

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

SECTION 8. INDEPENDENT CONTRACTOR RELATIONSHIPS[; INDEMNIFICATION]

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

Participating Providers are responsible for any health services rendered to their **Member** patients. **We** make no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any **Physician**, **Hospital** or other **Participating Provider**. A **Provider's** participation may be terminated at any time without advance notice to the **Contract Holder** or **Members**, subject to applicable law. **Participating Providers** provide health care diagnosis, treatment and services for **Members**. **We** administer and determine plan benefits. In Compliance with Washington law, RCW 48.43.545(1)(a)), **We** adhere to the same accepted standard of care for health care providers under RCW 7.70 when arranging for the provision of **Medically Necessary** health care services to **Members**.

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

[8.3 **Indemnification**. The **Parties** agree that **Contract Holder's** employee benefit plan is a "plan" within the meaning of Section 3 (3) of ERISA, unless specifically exempt thereunder. Generally, ERISA preempts all non-insurance state laws insofar as they relate to an employee benefit plan covered by ERISA. Therefore, there should be no liability by **Us** or **Contract Holder** to third parties pursuant to state law that arises out of this **Group Agreement**, **Our** performance hereunder, or **Contract Holder's** role as employer or Plan Sponsor.

[However, in order to fully define their indemnity obligations (a) in light of the possibility of a change in law affecting ERISA preemption of state law and (b) in the case of an action under ERISA, the **Parties** agree to the following:

- **We** shall indemnify and hold harmless **Contract Holder** for that portion of any liability, settlement and related expense (including the cost of legal defense) which was caused solely, directly and independently of all other causes by **Our** fraud, willful misconduct, criminal misconduct, or material breach of this **Group Agreement**.

- **Contract Holder** shall indemnify and hold harmless **Us**, **Our** affiliates and their respective directors, officers, eligible individuals or agents, for that portion of any liability, settlement and related expense (including the cost of legal defense) which was caused by **Contract Holder's** negligence, breach of this **Group Agreement**, breach of applicable state and federal laws, willful misconduct, criminal conduct, fraud, or its breach of a fiduciary responsibility in the case of an action under ERISA, related to or arising out of this **Group Agreement** or **Contract Holder's** role as employer or Plan Sponsor, as defined by ERISA.

The party seeking indemnification under the first or second bullet above must notify the indemnifying party promptly in writing of any actual or threatened action, suit or proceeding to which it claims such indemnity

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

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

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

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

- No statement made by **Contract Holder** or any **Member** shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing.

- No statement made by **Contract Holder** shall be the basis for voiding this **Group Agreement** after it has been in force for two years from its effective date.

9.9 **Assignability.** No rights or benefits under this **Group Agreement** are assignable by **Contract Holder** to any other party unless approved by **HCSC**.

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

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

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

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

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

9.15 **Inability to Arrange Services.** If due to circumstances not within **Our** reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection,

disability of a significant part of **Our Participating Providers** or entities with whom **We** have contracted for services under this **Group Agreement**, or similar causes, the provision of medical or **Hospital** benefits or other services provided under this **Group Agreement** is delayed or rendered impractical, **We** shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid **Premiums** held by **Us** on the date such event occurs. **We** are required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

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

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

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

[9.[18] **Workers' Compensation.** **Contract Holder** is responsible for protecting **Our** interests in any Workers' Compensation claims or settlements with any eligible individual. **We** shall be reimbursed for all paid medical expenses which have occurred as a result of any work related injury that is compensable or settled in any manner.

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