



**Cigna HealthCare of
Arizona, Inc.
HMO**

This document takes the place of any documents previously
issued to you which described your benefits.



NOTICE

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.myCigna.com or contact customer service at the phone number listed on the back of your ID card.

Selection of a Primary Care Provider

Your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.myCigna.com or contact customer service at the phone number listed on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

NOTICE

PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)

The group agreement is amended as stated below.

In the event of a conflict between the provisions of your plan documents and the provisions of this notice, the provisions that provide the better benefit shall apply.

Clinical Trials

Benefits are payable for Routine Patient Services associated with an approved clinical trial (Phases I-IV) for treatment of cancer or other life-threatening diseases or conditions for a covered person who meets the following requirements:

1. Is eligible to participate in an approved clinical trial according to the trial protocol with respect to the prevention, detection or treatment of cancer or other life-threatening disease or condition; and
2. Either
 - the referring health care professional is a participating health care provider and has concluded that the individual's participation in such a trial would be appropriate based upon the individual meeting the conditions described in Paragraph (1); or
 - the covered person provides medical and scientific information establishing that his participation in such a trial would be appropriate based on the individual meeting the conditions described in Paragraph (1).

For purposes of clinical trials, the term "life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

An approved clinical trial must meet one of the following requirements:

- be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
- be conducted under an investigational new drug application reviewed by the Food and Drug administration;
or
- involve a drug trial that is exempt from having such an investigational new drug application.

Routine Patient Services are costs associated with the provision of health care items and services including drugs, items, devices and services typically covered by Cigna for a covered patient who is not enrolled in a clinical trial, including the following:

- services typically provided absent a clinical trial;
- services required for the clinically appropriate monitoring of the investigational drug, device, item or service;
- services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service; and
- reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications.

Routine Patient Services do not include:

- the investigational item, device, or service itself; or
- items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

Clinical trials conducted by non-participating providers will be covered at the in-network benefit level if:

- there are not in-network providers participating in the clinical trial that are willing to accept the individual as a patient; or
- the clinical trial is conducted outside the individual's state of residence.

Exclusions and Limitations

Any services and supplies for or in connection with experimental, investigational or unproven services.

Experimental, investigational or unproven services do not include routine patient care costs related to qualified clinical trials as described in your plan document.

Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be: not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or the subject of review or approval by an Institutional Review Board for the proposed use.

Thank you for choosing Cigna.

We are pleased to provide important information about your HMO plan.

Your plan:

- **Does more than provide coverage when you're sick or injured.** We focus on helping you take care of yourself so you can stay your healthiest. Participate with your health care professional in health decisions and have your health care professional give you information about your medical condition and your treatment options, regardless of benefits coverage or cost. You have the right to receive this information in terms you understand.
- **Includes preventive care services.** We cover physicals, child immunizations, and women's health services such as no-referral OB/GYN checkups, mammograms and Pap tests. You'll also receive discounts on health and wellness programs and services.
- **Covers emergency and urgent care, 24 hours a day, worldwide.** Receive medical treatment that is available when you need it and is handled in a way that respects your privacy and dignity.

It's easy to get the information you need.

- **myCigna.com** offers a number of self-service features. You can review your plan information; find participating physicians, specialists, pharmacies and hospitals closest to home or work; view the status of your claims; order a new Cigna ID card; or change your PCP.
- **Customer Service Representatives** are ready to answer your questions and help solve problems. Just call the toll-free number on your Cigna HealthCare ID card. Get information you need about your health care plan, including information about services that are covered, services that are not covered and any costs that you will be responsible for paying.
- **Your Cigna ID card** lists the toll-free Customer Service phone number, your PCP's name and phone number, and payment information. Show your Cigna ID card before you receive care.
- **Our Commitment to Quality** guide gives you access to the latest information about our program activities and results, including how we met our goals, as well as details about key guidelines and procedures. Log on to www.myCigna.com to view this information. If you have questions about the quality program, would like to provide your feedback and/or cannot access the information online and would like a paper copy, please call the number on the back of your Cigna ID card.



We want you to be satisfied with your Cigna HealthCare plan. If you ever have a question about your plan or how to obtain services and supplies, just call. We're here to help.

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GROUP SERVICE AGREEMENT

Section I. Definitions of Terms Used in This Group Service Agreement

The following definitions will help you in understanding the terms that are used in this Group Service Agreement. As you are reading this Group Service Agreement you can refer back to this section. We have identified defined terms throughout the Agreement by capitalizing the first letter of the term.

Agreement

This Agreement, the Face Sheet, the Schedule of Copayments, any optional Riders, any other attachments, your Enrollment Application, and any subsequent written amendment or written modification to any part of the Agreement.

Anniversary Date of Agreement

The date written on the Face Sheet as the Agreement anniversary date.

Contract Year

The 12-month period beginning at 12:01 a.m. on the first day of the initial term or any renewal term and ending at 12:01 a.m. on the next anniversary of that date.

Copayment

The amount shown in the Schedule of Copayments that you pay for certain Covered Services and Supplies. The Copayment may be a fixed dollar amount or a percentage of the Participating Providers negotiated charge. When the Participating Provider has contracted with the Healthplan to receive payment on a basis other than a fee-for-service amount, the charge may be calculated based on a Healthplan-determined percentage of actual billed charges.

Custodial Services

Any services that are of a sheltering, protective or safeguarding nature. Such services may include a stay in an institutional setting, at-home care or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in daily living. Custodial care also can provide medical services given mainly to maintain the person's current state of health. These services cannot be intended to greatly

improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself.

Custodial Services include but are not limited to:

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as: a) walking, b) grooming, c) bathing, d) dressing, e) getting in or out of bed, f) toileting, g) eating, h) preparing foods, or i) taking medications that can be self administered, and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

Days

Calendar days; not 24 hour periods unless otherwise expressly stated.

Dependent

An individual in the Subscriber's family who is enrolled as a Member under this Agreement. You must meet the Dependent eligibility requirements in "Section II. Enrollment and Effective Date of Coverage" to be eligible to enroll as a Dependent.

Emergency Services

Emergency Services are defined in "Section IV. Covered Services and Supplies."

Enrollment Application

The enrollment process that must be completed by an eligible individual in order for coverage to become effective.

Essential Health Benefits

Means, to the extent covered under the plan, expenses incurred with respect to covered services, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and

I. Definitions of Terms Used In this Group Service Agreement

chronic disease management and pediatric services, including oral and vision care.

Face Sheet

The part of this Agreement that contains certain provisions affecting the relationship between the Healthplan and the Group. You can get a copy of the Face Sheet from the Group.

Group

The employer, labor union, trust, association, partnership, government entity, or other organization listed on the Face Sheet to this Agreement which enters into this Agreement and acts on behalf of Subscribers and Dependents who are enrolled as Members in the Healthplan.

Healthplan

The Cigna HealthCare health maintenance organization (HMO) which is organized under applicable law and is listed on the Face Sheet to this Agreement. Also referred to as “we”, “us” or “our”.

Healthplan Medical Director

A Physician charged by the Healthplan to assist in managing the quality of the medical care provided by Participating Providers in the Healthplan; or his designee.

Medical Services

Professional services of Physicians or Other Participating Health Professionals (except as limited or excluded by this Agreement), including medical, psychiatric, surgical, diagnostic, therapeutic, and preventive services.

Medically Necessary/Medical Necessity

Medically Necessary Covered Services and Supplies are those determined by the Healthplan Medical Director to be:

- required to diagnose or treat an illness, injury, disease or its symptoms; and
- in accordance with generally accepted standards of medical practice; and
- clinically appropriate in terms of type, frequency, extent, site and duration; and

- not primarily for the convenience of the patient, Physician, or other health care provider; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Healthplan Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining the least intensive setting.

Member

An individual meeting the eligibility criteria as a Subscriber or a Dependent who is enrolled for Healthplan coverage and for whom all required Prepayment Fees have been received by the Healthplan. Also referred to as “you” or “your”.

Membership Unit

The unit of Members made up of the Subscriber and his Dependent(s).

Open Enrollment Period

The period of time established by the Healthplan and the Group as the time when Subscribers and their Dependents may enroll for coverage. The Open Enrollment Period occurs at least once every Contract Year.

Other Participating Health Care Facility

Other Participating Health Care Facilities are any facilities other than a Participating Hospital or hospice facility that is operated by or has an agreement to render services to Members. Examples of Other Participating Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation hospitals and sub-acute facilities.

Other Participating Health Professional

An individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver Medical Services and who has an agreement with the Healthplan to provide Covered Services and Supplies to Members. Other Participating Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses.

I. Definitions of Terms Used In this Group Service Agreement

Participating Hospital

An institution licensed as an acute care hospital under the applicable state law, which has an agreement to provide hospital services to Members.

Participating Physician

A Primary Care Physician (PCP) or other Physician who has an agreement to provide Medical Services to Members.

Participating Provider

Participating Providers are Participating Hospitals, Participating Physicians, Other Participating Health Professionals, and Other Participating Health Care Facilities.

Patient Protection and Affordable Care Act of 2010

Means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Physician

An individual who is qualified to practice medicine under the applicable state law (or a partnership or professional association of such people) and who is a licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.).

Prepayment Fee

The sum of money paid to the Healthplan by the Group in order for you to receive the Services and Supplies covered by this Agreement.

Primary Care Physician (PCP)

A Physician who practices general medicine, family medicine, internal medicine or pediatrics who, through an agreement with the Healthplan, provides basic health care services to you if you have chosen him as your Primary Care Physician (PCP). Your Primary Care Physician (PCP) also arranges specialized services for you.

Primary Plan

The Plan that determines and provides or pays its benefits without taking into consideration the existence of any other Plan.

Prior Authorization

The approval a Participating Provider must receive from the Healthplan Medical Director, prior to services being rendered, in order for certain Services and Supplies to be covered under this Agreement.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

- The order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
- The order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
- The order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- The order states the period to which it applies; and
- If the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such notice meets the requirement above.

Referral

The approval you must receive from your PCP in order for the services of a Participating Provider, other than the PCP, participating OB/GYN, or chiropractic physician to be covered.

Rider

An addendum to this Agreement between the Group and the Healthplan.



I. Definitions of Terms Used In this Group Service Agreement

Schedule of Copayments

The section of this Agreement that identifies applicable Copayments and maximums.

You/Your

The Subscriber and/or any of his Dependents.

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Service Area

The geographic area, as described in the Provider Directory applicable to your plan, where the Healthplan is authorized to provide services.

Stabilize

Means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Subscriber

An employee, retiree or a participant in the Group, who is enrolled as a Member under this Agreement. You must meet the requirements contained in “Section II. Enrollment and Effective Date of Coverage” to be eligible to enroll as a Subscriber.

Total Copayment Maximums

The total amount of Copayments that an individual Member or Membership Unit must pay within a Contract Year. When the individual Member or Membership Unit has paid applicable Copayments up to the Total Copayment Maximums, that Member or Membership Unit will not be required to pay Copayments for those Services and Supplies for the remainder of the Contract Year. It is the Subscriber's responsibility to maintain a record of Copayments which have been paid and to inform the Healthplan when the amount reaches the Total Copayment Maximums. The Total Copayment Maximums and the Copayments that apply toward these maximums are identified in the Schedule of Copayments.

Urgent Care

Urgent Care is defined in “Section IV Covered Services and Supplies.”

We/Us/Our

Cigna HealthCare of Arizona, Inc.

II. Enrollment and Effective Date of Coverage

Section II. Enrollment and Effective Date of Coverage

Who Can Enroll as a Member

To be eligible for covered Services and Supplies you must be enrolled as a Member. To be eligible to enroll as a Member you must meet either the Subscriber or Dependent eligibility criteria listed below. You must also meet and continue to meet the Group-specific enrollment and eligibility rules on the Face Sheet.

A. To be eligible to enroll as a Subscriber, you must:

1. be an employee of the Group or a participant in the Group; and
2. reside or work in the Service Area; and
3. meet and continue to meet these criteria.

B. To be eligible to enroll as a Dependent, you must:

1. be the Subscriber's legal spouse; or
2. be the natural child, step-child, or adopted child of the Subscriber; or the child for whom the Subscriber is the legal guardian, legally placed with the Subscriber for adoption, or supported pursuant to a court order imposed on the Subscriber (including a qualified medical child support order), provided that the child:
 - i. has not yet reached age twenty-six (26); or
 - ii. the child is twenty-six (26) or older and continuously incapable of self-sustaining support because of mental retardation or a physical handicap which existed prior to attaining twenty-six (26) years of age and became mentally or physically handicapped prior to the age at which Dependent coverage would otherwise terminate under this Agreement. If the child becomes mentally or physically handicapped while covered under this Agreement you must submit proof of the

child's condition and dependence to us within thirty-one (31) days after the date the child ceases to qualify as a Dependent under subsection (i) and (ii) above or upon enrollment if the handicap existed prior to the enrollment. You may be required, from time to time during the next two (2) years, to provide proof of the continuation of the child's condition and dependence. Thereafter, you may be required to provide such proof only once a year.

A Subscriber's grandchild is not eligible for coverage unless they meet the eligibility criteria for a Dependent.

NOTE: A child eligible to enroll as a Dependent under this Agreement who resides outside of the Service Area, is entitled to receive, while outside the Service Area, only out-of-area emergency benefits under the "Emergency Services" provision of the "Services and Benefits" section.

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C. To be eligible to enroll as a domestic partner, you must:

1. share a permanent residence with the Subscriber;
2. have resided with the Subscriber for not less than one year;
3. be at least eighteen years of age;
4. be financially interdependent with the Subscriber and have proven such interdependence by providing documentation of at least two of the following arrangements:
 - a. common ownership of real property or a common leasehold interest in such property;
 - b. common ownership of a motor vehicle;
 - c. a joint bank account or a joint credit account;

II. Enrollment and Effective Date of Coverage

- d. designation as a beneficiary for life insurance or retirement benefits or under the Subscriber's last will and testament;
 - e. assignments of a durable power of attorney or health care power of attorney; or
 - f. such other proof as is considered by the Healthplan to be sufficient to establish financial interdependency under the circumstances of a particular case.
5. not be a blood relative any closer than would prohibit legal marriage;
 6. have signed jointly with the Subscriber a notarized affidavit in form and content which is satisfactory to the Healthplan and make this affidavit available to the Healthplan; and
 7. have registered with the Subscriber as domestic partners if you reside in a state that provides for such registration.

Same and opposite sex partners are eligible to enroll as a domestic partner. You are not eligible to enroll as a domestic partner if either you or the Subscriber has signed a domestic partner affidavit or declaration with any other person within twelve months prior to designating each other as domestic partners under this Agreement; are currently legally married to another person; or have any other domestic partner, spouse or spouse equivalent of the same or opposite sex.

An eligible domestic partner's children who meet the Dependent eligibility requirements in "Section II. Enrollment and Effective Date of Coverage" are also eligible to enroll.

The "Continuation of Group Coverage under COBRA" section of this Agreement does not apply to the Subscriber's domestic partner and his Dependents.

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Enrollment and Effective Date of Coverage

A. Enrollment during an Open Enrollment Period

If you meet the Subscriber or Dependent eligibility criteria, you may enroll as a Member

during the Open Enrollment Period by submitting a completed Enrollment Application, together with any applicable fees, to the Group.

If enrolled during the Open Enrollment Period, your effective date of coverage is the first day of the Contract Year.

B. Enrollment after an Open Enrollment Period

1. If, after the Open Enrollment Period, you become eligible for coverage as a Subscriber or a Dependent, you may enroll as a Member within thirty-one (31) days of the day on which you met the eligibility criteria. To enroll, you must submit an Enrollment Application, together with any additional fees due, to the Group. If so enrolled, your effective date of coverage will be the day on which you meet the eligibility criteria.

If you do not enroll within the thirty-one (31) days, your next opportunity to enroll will be during the next Open Enrollment Period.

2. If you are a Subscriber who is enrolled as a Member, you may enroll a newborn child prior to the birth of the child or within thirty-one (31) days after the child's birth. A newborn child who is born while this Agreement is being paid for at OTHER than a single or two-party rate shall have coverage effective as of the date of birth. While not a pre-condition to such coverage, it is strongly recommended that a Subscriber submit to the Healthplan through the Group an enrollment application for the newborn child prior to the birth of the child or within thirty-one (31) days after birth to assist in the administration of the health care plan. Failure to inform the Healthplan of the birth of a child may result in a delay in the appropriate processing of claims for services.

A newborn child who is born while this Agreement is being paid for at single or two-party rate shall have coverage effective as of the date of birth, if prior to the birth or within thirty-one (31) days after the child's birth, the Subscriber submits to the Healthplan through the Group an enrollment application and pays the additional

II. Enrollment and Effective Date of Coverage

Prepayment Fees due. If these requirements are not met, the newborn child may be enrolled during the next designated Open Enrollment period.

3. If you are a Subscriber who is enrolled as a Member, you may enroll an adopted child or child for whom you have been granted legal guardianship within thirty-one (31) days of the date the child is legally placed with you for adoption or within 31 days of the date you are granted legal guardianship. A child who is legally adopted by or is placed with the Subscriber for adoption while this Agreement is being paid for at other than a single or two-party rate shall have coverage effective as of the date the child is placed with the Subscriber. While not a pre-condition to such coverage, it is strongly recommended that a Subscriber submit to the Healthplan through the Group an enrollment application for the adopted child within thirty-one (31) days after the date of placement to assist in the administration of the health care plan. Failure to inform the Healthplan of the adoption of a child may result in a delay in the appropriate processing of claims for services. If the child is placed with the Subscriber before the adoption process is completed, the Subscriber shall also submit to the Healthplan proof that the application and approval procedures for adoption pursuant to A.R.S. Section 8-105 or Section 8-108 have been completed.

A child who is legally adopted by or is placed with the Subscriber for adoption while this Agreement is being paid for at a single or two-party rate shall have coverage effective as of the date the child is placed with the Subscriber if, within thirty-one (31) days after the date of placement, the Subscriber submits to the Healthplan through the Group an enrollment application and the Group pays any additional Prepayment Fees due. If the adoption process is not completed and coverage has been provided to a child under this Agreement, the Subscriber shall pay the Healthplan for all services and benefits provided to the child at prevailing rates for

staff model services and at the contracted rates for other services.

C. Full and Accurate Completion of Enrollment Application

Each Subscriber must fully and accurately complete the Enrollment Application. False, incomplete or misrepresented information provided in any Enrollment Application may, in the Healthplan's sole discretion, cause the coverage of the Subscriber and/or his Dependents to be null and void from its inception.

D. Hospitalization on the Effective Date of Coverage

If you are confined in a hospital on the effective date of your coverage, you must notify us of such a hospitalization within two (2) days, or as soon as reasonably possible thereafter. When you become a Member of the Healthplan, you agree to permit the Healthplan to assume direct coordination of your health care. We reserve the right to transfer you to the care of a Participating Provider and/or Participating Hospital if the Healthplan Medical Director, in consultation with your attending Physician, determines that it is medically safe to do so.

If you are hospitalized on the effective date of coverage and you fail to notify us of this hospitalization, refuse to permit us to coordinate your care, or refuse to be transferred to the care of a Participating Provider or Participating Hospital, we will not be obligated to pay for any medical or hospital expenses that are related to your hospitalization following the first two (2) days after your coverage begins.

Section III. Agreement Provisions

A. Healthplan's Representations and Disclosures

1. The Healthplan is a for-profit health maintenance organization (HMO) which arranges for the provision of covered Services and Supplies through a network of Participating Providers. The list of Participating Providers is provided to all Members at enrollment without charge. If you would like another list of Participating Providers, please contact Member Services at the toll-free number found on your Cigna HealthCare ID card or visit the Cigna HealthCare web site at myCigna.com.
2. With the exception of any employed Physicians who work in a facility operated by the Healthplan (so-called "staff model" providers), the Participating Providers are independent contractors. They are not the agents or employees of the Healthplan and they are not under the control of the Healthplan or any Cigna company. All Participating Providers are required to exercise their independent medical judgment when providing care.
3. The Healthplan maintains all medical information concerning a Member as confidential in accordance with applicable laws and professional codes of ethics. A copy of the Healthplan's confidentiality policy is available upon request.
4. We do not restrict communication between Participating Providers and Members regarding treatment options.
5. Under federal law (the Patient Self-Determination Act), you may execute advance directives, such as living wills or a durable power of attorney for health care, which permit you to state your wishes regarding your health care should you become incapacitated.
6. Upon your admission to a participating inpatient facility, a Participating Physician other than your PCP may be asked to direct and oversee your care for as long as you are in the inpatient facility. This Participating

Physician is often referred to as an "inpatient manager" or "hospitalist."

7. The terms of this Agreement may be changed in the future either as a result of an amendment agreed upon by the Healthplan and the Group or to comply with changes in law. The Group or the Healthplan may terminate this Agreement as specified in this Agreement. In addition, the Group reserves the right to discontinue offering any plan of coverage.
8. **Choosing a Primary Care Physician**

When you enroll as a Member, you must choose a Primary Care Physician (PCP). Each covered Member of your family must also choose a PCP. If you do not select a PCP, we will assign one for you. If your PCP leaves the Cigna HealthCare network, you will be able to choose a new PCP. You may voluntarily change your PCP for other reasons but not more than once in any calendar month. We reserve the right to determine the number of times during a Contract Year that you will be allowed to change your PCP. If you select a new PCP before the fifteenth day of the month, the designation will be effective on the first day of the month following your selection. If you select a new PCP on or after the fifteenth day of the month, the designation will be effective on the first day of the month following the next full month. For example, if you notify us on June 10, the change will be effective on July 1. If you notify us on June 15, the change will be effective on August 1.

Your choice of a PCP may affect the specialists and facilities from which you may receive services. Your choice of a specialist may be limited to specialists in your PCP's medical group or network. Therefore, you may not have access to every specialist or Participating Provider in your Service Area. Before you select a PCP, you should check to see if that PCP is associated with the specialist or facility you prefer to use. If the Referral is not possible, you should ask the specialist or facility about which PCPs can make Referrals to them,

and then verify the information with the PCP before making your selection.

9. Referrals to Specialists

You must obtain a Referral from your PCP before visiting any provider other than your PCP in order for the visit to be covered. The Referral authorizes the specific number of visits that you may make to a provider within a specified period of time. If you receive treatment from a provider other than your PCP without a Referral from your PCP, the treatment is not covered.

Exceptions to the Referral process:

If you are a female Member, you may visit a qualified Participating Provider for covered obstetrical and gynecological services, as defined in "Section IV. Covered Services and Supplies," without a Referral from your PCP.

You do not need a Referral from your PCP for Emergency Services as defined in the "Section IV. Covered Services and Supplies." In the event of an emergency, get help immediately. Go to the nearest emergency room, the nearest hospital or call or ask someone to call 911 or your local emergency service, police or fire department for help. You do not need a Referral from your PCP for Emergency Services, but you do need to call your PCP as soon as possible for further assistance and advice on follow-up care.

In an emergency, you should seek immediate medical attention and then as soon as possible thereafter you need to call your PCP for further assistance and advice on follow-up care.

In an Urgent Care situation a Referral is not required but you should, whenever possible, contact your PCP for direction prior to receiving services.

Standing Referral to Specialist

You may apply for a standing referral to a provider other than your PCP when all of the following conditions apply:

1. You are a covered member of the Healthplan;
2. You have a disease or condition that is life threatening, degenerative, chronic or disabling;
3. Your PCP in conjunction with network specialist determines that your care requires another provider's expertise;
4. Your PCP determines that your disease or condition will require ongoing medical care for an extended period of time;
5. The standing referral is made by your PCP to a network specialist who will be responsible for providing and coordinating your specialty care; and
6. The network specialist is authorized by the Healthplan to provide the services under the standing referral.

We may limit the number of visits and time period for which you may receive a standing referral. If you receive a standing referral or any other referral from your PCP, that referral remains in effect even if the PCP leaves the Healthplan's network. If the treating specialist leaves the Healthplan's network or you cease to be a covered member, the standing referral expires.

10. Transition Care

There may be instances in which your PCP becomes unaffiliated with the Healthplan's network of Participating Providers. In such cases, you will be notified and provided assistance in selecting a new PCP.

However, in special circumstances, you may be able to continue seeing your doctor, even though he or she is no longer affiliated with the Healthplan. If you are a new Member, upon written request to the Healthplan, you may continue an active course of treatment with your current health care provider during a transitional period after the effective date of enrollment if both of the following apply:

1. You have a life threatening disease or condition, in which case the transitional

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period will not be more than thirty (30) days after the effective date of enrollment;

2. Entered the third trimester of pregnancy on the effective date of enrollment, in which case the transitional period includes the delivery and any care up to six weeks after the delivery that is related to the delivery.

If you have been receiving care and a continued course of covered treatment is Medically Necessary, you may be eligible to receive “transitional care” from the non-participating provider for up to thirty (30) days. You may also be eligible to receive transitional care if you are in your second trimester of pregnancy. In this case, transitional care may continue through your delivery and post-partum care. Such transitional care must be approved in advance by the Healthplan, and your doctor must agree to accept our reimbursement rate and to abide by the Healthplan’s policies and procedures and quality assurance requirements. There may be additional circumstances where continued care by a provider no longer participating in the Healthplan’s network will not be available, such as when the provider loses his license to practice or retires.

If you are a new Member whose health care provider is not a member of the Healthplan’s network and you (i) are receiving an on-going course of treatment for a life-threatening disease or condition, or a degenerative or disabling disease or condition, or (ii) have entered your second trimester or pregnancy as of the effective date of your enrollment, you may be eligible to receive continuity of care from that non-participating provider for a transitional period of up to sixty (60) days, or the post partum period directly related to the delivery of your child. Such continuity of care must be approved in advance by the Healthplan, and your doctor must agree to accept our reimbursement rate and to abide by the Healthplan policies and procedures and quality assurance requirements. There may be additional circumstances where continued

care by a provider no longer participating in the Healthplan’s network will not be available, such as when the provider loses his/her license to practice or retires.

11. Provider Compensation

We compensate our Participating Providers in ways that are intended to emphasize preventive care, promote quality of care, and assure the most appropriate use of Medical Services. You can discuss with your provider how he is compensated by us. The methods we use to compensate Participating Providers are:

Discounted fee for service – payment for service is based on an agreed upon discounted amount for the services provided.

Capitation – Physicians, provider groups and Physician/hospital organizations are paid a fixed amount at regular intervals for each Member assigned to the Physician, provider group or Physician/hospital organization, whether or not services are provided. This payment covers Physician and/or, where applicable, hospital or other services covered under the benefit plan. Medical groups and Physician/hospital organizations may in turn compensate providers using a variety of methods.

Capitation offers health care providers a predictable income, encourages Physicians to keep people well through preventive care, eliminates the financial incentive to provide services that will not benefit the patient, and reduces paperwork.

Providers paid on a “capitated” basis may participate with us in a risk sharing arrangement. They agree upon a target amount for the cost of certain health care services, and they share all or some of the amount by which actual costs are over target. Provider services are monitored for appropriate utilization, accessibility, quality and Member satisfaction.

We may also work with third parties who administer payments to Participating Providers. Under these arrangements, we pay the third party a fixed monthly amount for these services. Providers are

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compensated by the third party for services provided to Healthplan participants from the fixed amount. The compensation varies based on overall utilization.

Salary – Physicians and other providers who are employed to work in our medical facilities are paid a salary. The compensation is based on a dollar amount, decided in advance each year, that is guaranteed regardless of the services provided. Physicians are eligible for any annual bonus based on quality of care, quality of service and appropriate use of Medical Services.

Bonuses and Incentives – Eligible Physicians may receive additional payments based on their performance. To determine who qualifies, we evaluate Physician performance using criteria that may include quality of care, quality of service, accountability and appropriate use of Medical Services.

Per Diem – A specific amount is paid to a hospital per day for all health care received. The payment may vary by type of service and length of stay.

Case Rate – A specific amount is paid for all the care received in the hospital for each standard service category as specified in our contract with the provider (e.g., for a normal maternity delivery).

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B. Member's Rights, Roles and Representations

You have the right to:

1. Medical treatment that is available when you need it and is handled in a way that respects your privacy and dignity.
2. Get the information you need about your health care plan, including information about services that are covered, services that are not covered, and any costs that you will be responsible for paying.
3. Have access to a current list of providers in our network and have access to information about a particular provider's education, training and practice.

4. Select a Primary Care Physician (PCP) for yourself and each covered Member of your family, and to change your PCP for any reason.
5. Have your medical information kept confidential by our employees and your health care provider. Confidentiality laws and professional rules of behavior allow us to release medical information only when it's required for your care, required by law, necessary for the administration of your plan or to support our programs or operations that evaluate quality and service. We may also summarize information in reports that do not identify you or any other participants specifically.
6. Have your health care provider give you information about your medical condition and your treatment options, regardless of benefit coverage or cost. You have the right to receive this information in terms you understand.
7. Learn about any care you receive. You should be asked for your consent to all care unless there is an emergency and your life and health are in serious danger.
8. Refuse medical care. If you refuse medical care, your health care provider should tell you what might happen. We urge you to discuss your concerns about care with your PCP or another Participating Physician. Your doctor will give you advice, but you will always have the final decision.
9. Be heard. Our complaint-handling process is designed to hear and act on your complaint or concern about us and/or the quality of care you receive, provide a courteous, prompt response, and to guide you through our appeals process if you do not agree with our decision.
10. Make recommendations regarding our policies on Member rights and responsibilities. If you have recommendations, please contact Member Services at the toll-free number on your Cigna HealthCare ID card.

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Your role is to:

1. Review and understand the information you receive about your health care plan. Please call Cigna HealthCare Member Services when you have questions or concerns.
2. Understand how to obtain covered Services and Supplies that are provided under your plan.
3. Show your Cigna HealthCare ID card before you receive care.
4. Schedule a new patient appointment with any new Cigna HealthCare PCP; build a comfortable relationship with your doctor; ask questions about things you don't understand; and follow your doctor's advice. You should also understand that your condition may not improve and may even get worse if you don't follow your doctor's advice.
5. Understand your health condition and work with your doctor to develop treatment goals that you both agree upon, to the extent that this is possible.
6. Provide honest, complete information to the providers caring for you.
7. Know what medicine you take, why, and how to take it.
8. Pay all Copayments for which you are responsible at the time the service is received.
9. Keep scheduled appointments and notify the doctor's office ahead of time if you are going to be late or miss an appointment.
10. Pay all charges for missed appointments and for services that are not covered by your plan.
11. Voice your opinions, concerns or complaints to Cigna HealthCare Member Services and/or your provider.
12. Notify your employer as soon as possible about any changes in family size, address, phone number or membership status.

You represent that:

1. The information provided to us and the Group in the Enrollment Application is complete and accurate.
2. By enrolling in the Healthplan, you accept and agree to all terms and conditions of this Agreement.
3. By presenting your Cigna HealthCare ID card and receiving treatment and services from our Participating Providers, you authorize the following to the extent allowed by law:
 - a. any provider to provide us with information and copies of any records related to your condition and treatment;
 - b. any person or entity having confidential information to provide any such confidential information upon request to us, any Participating Provider, and any other provider or entity performing a service, for the purpose of administration of the plan, the performance of any Healthplan program or operations, or assessing or facilitating quality and accessibility of health care Services and Supplies;
 - c. us to disclose confidential information to any persons, company or entity to the extent we determine that such disclosure is necessary or appropriate for the administration of the plan, the performance of the Healthplan programs or operations, assessing or facilitating quality and accessibility of healthcare Services and Supplies, or reporting to third parties involved in plan administration; and
 - d. that payment be made under Part B of Medicare to us for medical and other services furnished to you for which we pay or have paid, if applicable.

This authorization will remain in effect until you send us a written notice revoking it or for such shorter period as required by law. Until revoked, we and other parties may rely upon this authorization.

With respect to Members, confidential information includes any medical, dental, mental health, substance abuse, communicable disease, AIDS and HIV related information and disability or employment related information.

4. You will not seek treatment as a Cigna HealthCare Member once your eligibility for coverage under this Agreement has ceased.

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C. When You Have a Complaint or an Appeal

(For the purposes of this section, any reference to “you”, “your” or “Member” also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.)

We want you to be completely satisfied with the care you receive. That’s why we’ve established a process for addressing your concerns and solving your problems. The following describes the process by which Members may obtain information and submit concerns regarding service, benefits, and coverage. For more information, see the Benefit Inquiry and Appeals Information Packet (“Appeal Packet”). Upon membership renewal or at any time thereafter, you may request an additional Appeal Packet by contacting Member Services at the toll-free number that appears on your Cigna HealthCare ID card or Benefit Identification card.

Start with Customer Services

We’re here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you can call us at our toll-free number and explain your concern to one of our Customer Service representatives. Please call us at the Customer Services Toll-Free Number that appears on your Cigna HealthCare ID Card or Benefit Identification card.

We’ll do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we’ll get back to you as soon as possible, but in any case within thirty (30) days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

HEALTHPLAN has a three step appeals procedure for coverage decisions. To initiate an appeal, you can submit a request for an appeal by calling or writing within two (2) years of receipt of a denial notice. You can call us at the Customer Service Toll-Free Number that appears on your Benefit Identification Card, explanation of benefits or claim form, or you can write to us at the following address:

Cigna HealthCare of Arizona, Inc.
National Appeals Organization (NAO)
P.O. Box 188011
Chattanooga, TN 37422

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by calling the toll-free number on your Cigna HealthCare ID card or Benefit Identification card.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

Within five (5) business days after receiving your request for review, the Healthplan will mail you and your Primary Care Physician (“PCP”) or treating Provider a notice indicating that your request was received, and a copy of the Appeal Packet (sent to PCP or treating Provider upon request). For level one appeals, we will respond in writing with a decision within fifteen (15) calendar days after we receive an appeal for a pre-service or concurrent coverage determination, and within thirty (30) calendar days after we receive an appeal for a post-service coverage determination. If more time or information is needed to make the pre-service or concurrent determination, we will notify you in writing to request an extension of up to fifteen calendar days and to specify any additional information needed to complete the review. You may request that the appeal process be expedited if, (a) your PCP or treating Provider certifies in writing and provides supporting documentation

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that the time frames under this process are likely to cause a significant negative change in your medical condition which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient hospital stay.

If you request that your appeal be expedited based on (a) above, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited level-one appeal would be detrimental to your medical condition.

When an appeal is expedited, we will respond orally and in writing with a decision within the lesser of one (1) business day or seventy-two (72) hours.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To initiate a level two appeal, you must submit a request for the appeal in writing to the following address:

Cigna HealthCare of Arizona, Inc.
National Appeals Organization (NAO)
P.O. Box 188011
Chattanooga, TN 37422

If the appeal involves a coverage decision based on issues of Medical Necessity, clinical appropriateness or experimental treatment, a medical review will be conducted by a Physician reviewer in the same or similar specialty as the care under consideration, as determined by the Healthplan Medical Director. For all other coverage plan-related appeals, a second-level review will be conducted by someone who was a) not involved in any previous decision related to your appeal, and b) not a subordinate of previous decision makers. Provide all relevant documentation with your second-level appeal request.

Please send your review request relating to denial of a requested service that has not already been provided within 365 days of the last denial. Your review requests relating to payment of a service already provided should be sent within two (2) years of the last denial. To help us make a decision on your appeal, you or your provider should also send us any more information (that

you haven't already sent us) to show why we should authorize the requested service or pay the claim.

For level two appeals we will acknowledge in writing that we have received your request within 5 working days after receiving your request. For required pre-service and concurrent care coverage determinations the Healthplan's review will be completed within fifteen (15) calendar days and for post-service claims, the Healthplan's review will be completed within thirty (30) calendar days.

If more time or information is needed to make the pre-service or concurrent determination, we will notify you in writing to request an extension of up to fifteen (15) calendar days and to specify any additional information needed to complete the review.

In the event any new or additional information (evidence) is considered, relied upon or generated by the Healthplan in connection with the level-two appeal, the Healthplan will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by the Healthplan, the Healthplan will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

You may request that the appeal process be expedited if, your PCP or treating Provider certifies in writing and provides supporting documentation that the time frames under this process are likely to cause a significant negative change in your medical condition which cannot be managed without the requested services; or your appeal involves non-authorization of an admission or continuing inpatient hospital stay. When an appeal is expedited, we will respond orally with a decision within seventy-two (72) hours, followed up in writing.

After completing the Level One appeal process, the Healthplan has the option to send your appeal directly to External Independent Review without making a decision at the Level Two appeal process.

External Independent Review

1. Eligibility

Under Arizona law, a Member may seek an Expedited or Standard External Independent Review only after seeking any available Expedited Review, Level 1 Appeal, and Level 2 Appeal. Your request for an Expedited or Standard External Independent Review should be submitted in writing.

2. Deadlines Applicable to the Standard External Independent Review Process

After receiving written notice from the Healthplan that your Level 2 Appeal has been denied, you have thirty (30) calendar days to submit a written request to the Healthplan for External Independent Review, including any additional material justification or documentation that you have not already sent to us to support your request for the service or payment of a claim.

a. Medical Necessity Issues

These are cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for, are not medically necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization (“IRO”), that is procured by the Arizona Insurance Department, and not connected with our company. The IRO provider must be a provider who typically manages the condition under review. If your appeal for External Independent Review involves an issue of medical necessity:

- (1) Within five (5) business days of receipt of your request for External Independent Review, the Healthplan will:
 - mail a written notice to you, your PCP or treating provider, and the Director of the Arizona Department

of Insurance (“Director of Insurance”) of your request for External Independent Review, and

- Send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

- (2) Within 5 days of receiving our information, the Insurance Director must send all submitted information to an external independent review organization (the “IRO”).
- (3) Within 21 days of receiving the information the IRO must make a decision and send the decision to the Insurance Director.
- (4) Within 5 business days of receiving the IRO’s decision, The Insurance Director must mail a notice of the decision to us, you, and your treating provider. If the IRO decides that the Healthplan should provide the service or pay the claim, the Healthplan must then authorize the service or pay the claim. If the IRO agrees with the Healthplan’s decision to deny the service or payment, the appeal is over. Your only further option is to pursue your claim in Superior Court.

b. Coverage Issues

These are cases where we have denied coverage because we believe the requested service is not covered under your evidence of coverage. For contract coverage cases, the Arizona Insurance Department is the independent reviewer. If your appeal for External Independent Review

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involves an issue of service or benefits coverage or a denied claim:

(1) Within five (5) business days of receipt of your request for External Independent Review, the Healthplan will:

- mail a written notice to you, your PCP or treating provider, and the Director of Insurance of your request for External Independent Review, and
- send the Director of Insurance: your request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and any clinical reasons for our decision; and the relevant portions of our utilization review guidelines.

(2) Within fifteen (15) business days of the Director's receipt of your request for External Independent Review from the Healthplan, the Director of Insurance will:

- determine whether the service or claim is covered, and
- mail the decision to the Healthplan. If the Director decides that we should provide the service or pay the claim, we must do so.

(3) If the Director of Insurance is unable to determine an issue of coverage, the Director will forward your case to an IRO. The IRO will have 21 days to make a decision and send it to the Insurance Director. The Insurance Director will have 5 business days after receiving the IRO's decision to send the decision to us, you, and your treating provider.

(4) The Healthplan will provide any covered service or pay any covered claim determined to be medically necessary by the independent reviewer(s) and provide any service or pay any claim determined to be covered by the Director of Insurance regardless of whether the Healthplan elects to seek judicial review of the decision made through the External Independent Review Process.

(5) If you disagree with the Insurance Director's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If the Healthplan disagrees with the Insurance Director's final decision, the Healthplan may also request a hearing before the OAH. A hearing must be requested within 30 calendar days of receiving the Insurance Director's decision. OAH will schedule and complete a hearing for appeals from standard external independent review coverage decisions.

3. Deadlines Applicable to the Expedited External Independent Review Process

After receiving written notice from the Healthplan that your Expedited Level 2 Appeal has been denied, you have only 5 business days to submit a written request to the Healthplan for an Expedited External Independent Review. Your request should include any additional material justification or documentation that you have not already sent to us to support your request for the service or payment of a claim.

a. Medical Necessity Issues

If your appeal for Expedited External Independent Review involves an issue of medical necessity:

(1) Within 1 business day of receipt of your request for an Expedited External Independent Review, the Healthplan will:

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- mail a written acknowledgment to you, your PCP or treating provider, and the Director of your request for Expedited External Independent Review, and
 - forward to the Director your request for an Expedited External Independent Review, the terms of the agreement in your contract, all medical records and supporting documentation used to render the adverse decision, a summary description of the applicable issues including a statement of the Healthplan's decision, the criteria used and the clinical reasons for the decision, relevant portions of the Healthplan's utilization review plan and the name and the credentials of the licensed health care provider who reviewed the case.
- (2) Within 2 business days after the Director receives the information outlined above, the Director will choose an independent review organization (IRO) and forward to the organization all of the information received by the Director.
- (3) Within 5 business days of receiving a case for Expedited External Independent Review from the Director, the IRO will evaluate and analyze the case and based on all the information received, render a decision and send the decision to the Director. Within 1 business day after receiving a notice of the decision from the IRO, the Director will mail a notice of the decision to you, your PCP or treating provider, and the Healthplan.
- b. Coverage Issues
- If your appeal for Expedited External Independent Review involves a contract coverage issue:
- (1) Within 1 business day of receipt of your request for an Expedited External Independent Review, the Healthplan will:
- mail a written acknowledgment to you, your PCP or treating provider, and the Director of your request for Expedited External Independent Review, and
 - forward to the Director your request for an Expedited External Independent Review, the terms of the agreement in your contract, all medical records and supporting documentation used to render the adverse decision, a summary description of the applicable issues including a statement of the Healthplan's decision, the criteria used and the clinical reasons for the decision, relevant portions of the Healthplan's utilization review plan and the name and the credentials of the licensed health care provider who reviewed the case.
- (2) Within 2 business days after receipt of all the information outlined above, the Director will determine if the service or claim is covered and mail a notice of the determination to you, your PCP or treating provider, and the Healthplan.
- (3) If the Director of Insurance is unable to determine an issue of coverage, the Director will forward your case to an IRO. The IRO will have 5 business days to make a decision and send it to the Director. The Director will have 1 business day after receiving the IRO's decision to send the decision to the Healthplan, you and your treating provider.
- (4) The Healthplan will provide any covered service or pay any covered claim determined to be medically necessary by the independent reviewer(s) and provide any service or pay any claim determined to be covered by the Director regardless of whether the Healthplan elects to seek judicial review of the decision made through the External Independent Review Process.
- (5) If you disagree with the Insurance Director's final decision on a contract coverage issue, you may request a

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hearing with the Office of Administrative Hearings (“OAH”). If the Healthplan disagrees with the Director’s final decision, the Healthplan may also request a hearing before OAH. A hearing must be requested within 30 days of receiving the Director’s decision.

Under Arizona law, if you intend to file suit regarding a denial of benefit claim or services you believe are medically necessary, you are required to provide written notice to the Healthplan at least thirty (30) days before filing the suit stating your intention to file suit and the basis for your suit. You must include in your notice the following:

- Member Name
- Member Identification Number
- Member Date of Birth
- Basis of Suit (reasons, facts, date(s) of treatment or request)

Notice will be considered provided by you on the date received by the Healthplan. The notice of intent to file suit must be sent to the Healthplan via Certified Mail Return Receipt Request to the following address:

Attention: National Appeals Unit Director
Notice of Intent to File Suit
Cigna HealthCare of Arizona, Inc.
National Appeals Organization (NAO)
P.O. Box 188011
Chattanooga, TN 37422

Receipt of Documents

Any written notice, acknowledgment, request, decision or other written documents required to be mailed during the process is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. “Properly addressed” means your last known address.

Complaints to the Arizona Department of Insurance

The Director of the Arizona Department of Insurance is required by law to require any

Member who files a complaint with the Arizona Department of Insurance relating to an adverse decision to first pursue the review process established by the Arizona Legislature and the Healthplan as described above.

Appeal to the State of Arizona

If you need help in filing an appeal, or you have questions about the appeals process, you may call the Department’s Consumer Assistance Office at 602.912.8444 or 1.800.325.2548.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and will include: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the determination; (3) reference to the specific plan provisions on which the determination is based; (4) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (5) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (6) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; and (7) information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of an adverse determination will include a discussion of the decision.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which was (a) relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against HEALTHPLAN until you have completed the Level One and Level Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

Section IV. Covered Services And Supplies

The covered Services and Supplies available to Members under this plan are described below. Any applicable Copayments or limits are identified in the Schedule of Copayments.

Unless otherwise authorized in writing by the Healthplan Medical Director, covered Services and Supplies are available to Members only if:

- A. They are Medically Necessary and not specifically excluded in this Section or in Section V.
- B. Provided by your Primary Care Physician (PCP) or if your PCP has given you a Referral, by another Participating Provider. However, “Emergency Services” do not require a Referral from your PCP and do not have to be provided by Participating Providers. Also, you do not need a Referral from your PCP for “Obstetrical and Gynecological Services,” “Chiropractic Care Services,” and “Urgent Care.”
- C. Prior Authorization is obtained from the Healthplan Medical Director by the Participating Provider, for those services that require Prior Authorization. Services that require Prior Authorization include, but are not limited to, inpatient hospital services, inpatient services at any Other Participating Health Care Facility, Outpatient Facility Services, advanced radiological imaging, non-emergency ambulance, and Transplant Services. Prior authorization for non-emergency ambulance services may be obtained from a Participating Provider that is treating the Member.

Physician Services

All diagnostic and treatment services provided by Participating Physicians and Other Participating Health Professionals, including office visits, periodic health assessments, well-child care and routine immunizations provided in accordance with accepted medical practices, hospital care, consultation, and surgical procedures.

Inpatient Hospital Services

Inpatient hospital services for evaluation or treatment of conditions that cannot be adequately

treated on an ambulatory basis or in an Other Participating Health Care Facility. Inpatient hospital services include semi-private room and board; care and services in an intensive care unit; drugs, medications, biologicals, fluids, blood and blood products, and chemotherapy; special diets; dressings and casts; general nursing care; use of operating room and related facilities; laboratory and radiology services and other diagnostic and therapeutic services; anesthesia and associated services; inhalation therapy; radiation therapy; and other services which are customarily provided in acute care hospitals.

Outpatient Facility Services

Services provided on an outpatient basis, including: diagnostic and/or treatment services; administered drugs, medications, fluids, biologicals, blood and blood products; inhalation therapy; and procedures which can be appropriately provided on an outpatient basis, including certain surgical procedures, anesthesia, and recovery room services.

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Emergency Services and Urgent Care

Emergency Services Both In and Out of the Service Area. In the event of an emergency, get help immediately. Go to the nearest emergency room, the nearest hospital or call or ask someone to call 911 or your local emergency service, police or fire department for help. You do not need a Referral for Emergency Services, but you do need to call your PCP or the Cigna HealthCare 24-Hour Health Information LineSM as soon as possible for further assistance and advice on follow-up care. If you require specialty care or a hospital admission, your PCP or the Cigna HealthCare 24-Hour Health Information LineSM will coordinate it and handle the necessary authorizations for care or hospitalization. Participating Providers are on call twenty-four (24) hours a day, seven (7) days a week, to assist you when you need Emergency Services.

If you receive Emergency Services outside the Service Area, you must notify us as soon as reasonably possible. We may arrange to have you transferred to a Participating Provider for continuing or follow-up care if it is determined to be medically safe to do so.

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Emergency medical condition means a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

Emergency services means, with respect to an emergency medical condition: (a) a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and (b) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

Urgent Care Inside the Service Area. For Urgent Care inside the Service Area, you must take all reasonable steps to contact the Cigna HealthCare 24-Hour Health Information LineSM or your PCP for direction and you must receive care from a Participating Provider, unless otherwise authorized by your PCP or the Healthplan.

Urgent Care Outside the Service Area. In the event you need Urgent Care while outside the Service Area, you should, whenever possible, contact the Cigna HealthCare 24 Hour Health Information LineSM or your PCP for direction and authorization prior to receiving services.

Urgent Care is defined as medical, surgical, hospital and related health care services and testing which are not Emergency Services, but which are determined by the Healthplan Medical Director in accordance with generally accepted medical standards to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or are scheduled to receive services. Such care includes but is not limited to: dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that you should not travel due to any medical condition.

Continuing or Follow-up Treatment. Continuing or follow-up treatment, whether in or out of the Service Area, is not covered unless it is provided or arranged for by your PCP, a Participating Physician or upon Prior Authorization of the Healthplan Medical Director.

Notification, Proof of a Claim, and Payment. Inpatient hospitalization for any Emergency Services or Urgent Care requires notification to and authorization by the Healthplan Medical Director. Notification of inpatient hospitalization is required as soon as reasonably possible, but no later than within forty-eight (48) hours of admission. This requirement shall not cause denial of an otherwise valid claim if you could not reasonably comply, provided that notification is given to us as soon as reasonably possible. If you receive Emergency Services or Urgent Care from non-Participating Providers, you must submit a claim to us no later than sixty (60) days after the first service is provided. The claim shall contain an itemized statement of treatment, expenses, and diagnosis. This requirement shall not cause denial of an otherwise valid claim if you could not reasonably comply, provided you submit the claim and the itemized statement to us as soon as reasonably possible. Coverage for Emergency Services and Urgent Care received through non-Participating Providers shall be limited to covered services to which you would have been entitled under this Agreement, and you will be reimbursed for only the costs that you incur that you would not have incurred if you received the services in-network.

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Ambulance Service

Ambulance services to the nearest appropriate provider or facility. Prior authorization for non-emergency ambulance services may be obtained from a Participating Provider that is treating the Member.

Autism Spectrum Disorders

Any covered service and/or supply under this Agreement will not be excluded or denied based solely on a diagnosis of Autism Spectrum Disorder.

In addition, coverage will be provided for Medically Necessary Behavioral Therapy.

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Behavioral Therapy means interactive therapies derived from evidence based research, including applied behavior analysis which includes discrete trial training, pivotal response training, intensive intervention programs and early intensive behavioral intervention. Such therapy must be provided or supervised by a licensed or certified provider. Any exclusion within this Agreement that is inconsistent with such coverage does not apply.

Autism Spectrum Disorder means any of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association: Autistic Disorder, Asperger's Syndrome, Pervasive Developmental Disorder - Not Otherwise Specified.

Coverage for Autism Spectrum Disorder will not be subject to dollar limits, deductibles or coinsurance provisions that are less favorable than the dollar limits, deductible or coinsurance provisions that apply to physical illness generally under the terms of this Agreement.

Breast Reconstruction and Breast Prostheses

Following a mastectomy, the following Services and Supplies are covered:

- surgical services for reconstruction of the breast on which the mastectomy was performed;
- surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance;
- post-operative breast prostheses; and
- mastectomy bras and external prosthetics that meet external prosthetic placement needs.

During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Cancer Clinical Trials

Coverage shall be provided for medically necessary covered patient costs that are directly associated with a cancer clinical trial that is offered in the State of Arizona and in which the Member participates voluntarily. A cancer clinical trial is a course of treatment in which all of the following apply:

1. The treatment is part of a scientific study of a new therapy or intervention that is being conducted at an institution in the State of Arizona, that is for the treatment, palliation or prevention of cancer in humans and in which the scientific study includes all of the following: (a) specific goals; (b) a rationale and background for the study; (c) criteria for patient selection; (d) specific directions for administering the therapy and monitoring patients; (e) definition of quantitative measures for determining treatment response; and (f) methods for documenting and treating adverse reactions.
2. The treatment is being provided as part of a study being conducted in a phase I, phase II, phase III or phase IV cancer clinical trial.
3. The treatment is being provided as part of a study being conducted in accordance with a clinical trial approved by at least one of the following: (a) One of the National Institutes of Health; (b) A National Institutes of Health Cooperative Group or Center; (c) The United States Food and Drug Administration in the form of an investigational new drug application; (d) The United States Department of Defense; (e) The United States Department of Veteran Affairs; (f) a qualified research entity that meets the criteria established by the National Institutes of Health for grant eligibility; or (g) a panel of qualified recognized experts in clinical research within academic health institutions in the State of Arizona.
4. The proposed treatment or study has been reviewed and approved by an institutional review board of an institution in the State of Arizona.
5. The personnel providing the treatment or conducting the study (a) are providing the treatment or conducting the study within their scope of practice, experience and training and are capable of providing the treatment because of their experience, training and volume of patients treated to maintain expertise; (b) agree to accept reimbursement as payment in full from the Healthplan at the rates that are established by the Healthplan and that are not more than the level of reimbursement applicable to other similar services provided by

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the health care providers with the Healthplan's network.

6. There is no clearly superior, non-investigational treatment alternative.
7. The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as efficacious as any non-investigational alternative.

For the purposes of this specific covered Service and Benefit the following have the following meaning:

1. **“Cooperative Group”** – means a formal network of facilities that collaborates on research projects and that has an established national institutes of health approved peer review program operating within the group, including the National Cancer Institute Clinical Cooperative Group and The National Cancer Institute Community Clinical Oncology Program.
2. **“Institutional Review Board”** – means any board, committee or other group that is both: (a) formally designated by an institution to approve the initiation of and to conduct periodic review of biomedical research involving human subjects and in which the primary purpose of such review is to assure the protection of the rights and welfare of the human subjects and not to review a clinical trial for scientific merit; and (b) approved by the National Institutes of Health Office for Protection From Research Risks.
3. **“Multiple Project Assurance Contract”** – means a contract between an institution and the United States Department of Health and Human Services that defines the relationship of the institution to the United States Department of Health and Human Services and that sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.
4. **“Patient Cost”** – means any fee or expense that is covered under the Evidence of Coverage and that is for a service or treatment that would be required if the patient were receiving usual and customary care. Patient Cost does not include the cost: (a) of any drug or device provided in a

phase I cancer clinical trial; (b) of any investigational drug or device; (c) of non-health services that might be required for a person to receive treatment or intervention; (d) of managing the research of the clinical trial; (e) that would not be covered under the Member's contract; and (f) of treatment or services provided outside the State of Arizona.

Cosmetic Surgery

Reconstructive surgery that constitutes necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

Diabetic Service and Supplies

Coverage will be provided for the following Medically Necessary supplies, devices, and appliances prescribed by a health care provider for the treatment of diabetes: Test strips for glucose monitors and visual reading and urine testing strips; insulin preparations; glucagon; insulin cartridges and insulin cartridges for the legally blind; syringes and lancets (including automatic lancing devices); oral agents for controlling blood sugar that are included on the Formulary; blood glucose monitors and blood glucose monitors for the legally blind; and injection aids; to the extent coverage is required under Medicare, podiatric appliances for prevention of complications associated with diabetes; and any other device, medication, equipment or supply for which coverage is required under Medicare.

Eosinophilic Gastrointestinal Disorder

Amino acid-based formula that is ordered by a Physician or a registered nurse practitioner if;

- 1) You have been diagnosed with an Eosinophilic Gastrointestinal Disorder;
- 2) You are under continuous supervision of a Physician;
- 3) There is a risk of a mental or physical impairment without the use of the formula.

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Durable Medical Equipment

Purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Participating Physician and provided by a vendor approved by the

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Healthplan for use outside a Participating Hospital or Other Participating Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a member's misuse are the member's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the Healthplan Medical Director.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of illness or injury; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheel chairs and dialysis machines.

Durable Medical Equipment items that are not covered, include but are not limited to those that are listed below.

- **Bed related items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including non-power mattresses, custom mattresses and posturepedic mattresses.
- **Bath related items:** bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats and spas.
- **Chairs, Lifts and Standing Devices:** computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized - manual hydraulic lifts are covered if patient is two person transfer) and auto tilt chairs.
- **Fixtures to real property:** ceiling lifts and wheelchair ramps.
- **Car/van modifications.**
- **Air quality items:** room humidifiers, vaporizers, air purifiers, and electrostatic machines.

- **Blood/injection related items:** blood pressure cuffs, centrifuges, nova pens and needle-less injectors.
- **Other equipment:** heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adapters, Enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

External Prosthetic Appliances and Devices

The initial purchase and fitting of external prosthetic appliances and devices that are ordered by a Participating Physician, available only by prescription and are necessary for the alleviation or correction of illness, injury or congenital defect. Coverage for External Prosthetic Appliances and Devices is limited to the most appropriate and cost effective alternative as determined by the Healthplan Medical Director.

External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices, braces and splints.

Prostheses/Prosthetic Appliances and Devices

Prostheses/Prosthetic appliances and devices are defined as fabricated replacements for missing body parts. Prostheses/prosthetic appliances and devices include, but are not limited to:

- Basic limb prostheses;
- Terminal devices such as hands or hooks; and
- Speech prostheses.

Orthoses and orthotic devices

Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

- Non-foot orthoses - only the following non-foot orthoses are covered:
 - a. Rigid and semi-rigid custom fabricated orthoses,

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- b. Semi-rigid pre-fabricated and flexible orthoses; and
- c. Rigid pre-fabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthotics - custom foot orthoses are only covered as follows:
 - a. For Members with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
 - b. When the foot orthosis is an integral part of a leg brace, and it is necessary for the proper functioning of the brace;
 - c. When the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputation) and is necessary for the alleviation or correction of illness, injury, or congenital defect; and
 - d. For Members with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot, and there is reasonable expectation of improvement.

The following are specifically excluded orthosis and orthotic devices:

- Prefabricated foot orthoses;
- Cranial banding/cranial orthoses/other similar devices are excluded, except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- Orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- Orthoses primarily used for cosmetic rather than functional reasons; and
- Orthoses primarily for improved athletic performance or sports participation.

Braces

A brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

The following braces are specifically excluded:

- Copes scoliosis braces.

Splints

A splint is defined as an appliance for preventing movement of joints or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

- Replacement due to regular wear. Replacement for damage due to abuse or misuse by the member will not be covered; and
- Replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.

Coverage for replacement is limited as follows:

- No more than once every 24 months for Members 19 years of age and older;
- No more than once every 12 months for Members 18 years of age and under; and
- Replacement due to a surgical alteration or revision of the site.

The following are specifically excluded external prosthetic appliances and devices:

- External and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- Myoelectric prosthesis peripheral nerve stimulators.

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Family Planning Services (Contraception and Voluntary Sterilization)

Family planning services including: medical history; physical examination; related laboratory tests; medical supervision in accordance with generally accepted medical practice; other Medical Services;

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information and counseling on contraception; implanted/injected contraceptives; and, after appropriate counseling, Medical Services connected with surgical therapies (vasectomy or tubal ligation).

Genetic Testing

Genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease.

Genetic testing is only covered if:

- D. You have symptoms or signs of a genetically-linked inheritable disease;
- E. It has been determined that you are at risk for carrier status as supported by existing peer-reviewed, evidence-based scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
- F. The therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based scientific literature to directly impact treatment options.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if you are undergoing approved genetic testing, or if you have an inherited disease and are a potential candidate for genetic testing. Genetic counseling is limited to three (3) visits per Contract Year for both pre- and post-genetic testing.

Home Health Services

Home health services when you:

- Require skilled care;
- Are unable to obtain the required care as an ambulatory outpatient; and
- Do not require confinement in a hospital or Other Participating Health Care Facility.

Home health services are provided only if the Healthplan Medical Director has determined that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others for non-skilled care and/or Custodial Services (e.g. bathing, eating, toileting), home health services will only be provided for you during times when there is a family member or care giver present in the home to

meet your non-skilled care and/or Custodial Services needs.

Home health services are those skilled health care services that can be provided during visits by Other Participating Health Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Participating Health Professionals. Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit limitations. A visit is defined as a period of 2 hours or less. Home health services are subject to a maximum of 16 hours in total per day. Necessary consumable medical supplies and home infusion therapy administered or used by Other Participating Health Professionals in providing home health services are covered. Home health services do not include services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is an Other Participating Health Professional. Physical, occupational, and other Short-term Rehabilitative Therapy services provided in the home are not subject to the Home Health Services benefit limitations in the Schedule of Copayments, but are subject to the benefit limitations described under "Short-term Rehabilitative Therapy" in the Schedule of Copayments.

Hospice Services

Hospice care services which are provided under an approved hospice care program when provided to a Member who has been diagnosed by a Participating Physician as having a terminal illness with a prognosis of six months or less to live. Hospice care services include inpatient care; outpatient services; professional services of a Physician; services of a psychologist, social worker or family counselor for individual and family counseling; and home health services.

Hospice care services do not include the following:

- services of a person who is a member of your family or your dependent's family or who normally resides in your house or your dependent's house;
- services and supplies for curative or life-prolonging procedures;

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- services and supplies for which any other benefits are payable under the Agreement;
- services and supplies that are primarily to aid you or your dependent in daily living;
- services and supplies for respite (custodial) care; and
- nutritional supplements, non-prescription drugs or substances, medical supplies, vitamins or minerals.

Hospice care services are services provided by a Participating Hospital; a participating skilled nursing facility or a similar institution; a participating home health care agency; a participating hospice facility, or any other licensed facility or agency under a Medicare approved hospice care program.

A hospice care program is a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families; a program that provides palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness; and a program for persons who have a terminal illness and for the families of those persons.

A hospice facility is a participating institution or portion of a facility which primarily provides care for terminally ill patients; is a Medicare approved hospice care facility; meets standards established by the Healthplan; and fulfills all licensing requirements of the state or locality in which it operates.

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Inpatient Services at Other Participating Health Care Facilities

Inpatient services at Other Participating Health Care Facilities including semi-private room and board; skilled and general nursing services; Physician visits; physiotherapy; speech therapy; occupational therapy; x-rays; and administration of drugs, medications, biologicals and fluids.

Internal Prosthetic/Medical Appliances

Internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for non-functional body parts are covered, including testicular implants following medically necessary

surgical removal of testicles. Medically necessary repair, maintenance or replacement of a covered appliance is also covered.

Laboratory and Radiology Services

Laboratory services and radiation therapy and other diagnostic and therapeutic radiological procedures.

Mammograms

Mammograms for routine and diagnostic breast cancer screening as follows: a single baseline mammogram if you are age 35-39; once per every other Contract Year if you are age 40-49, or more frequently based on the recommendation of your PCP; and once per Contract Year if you are age 50 and older.

Maternity Care Services

Medical, surgical and hospital care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, spontaneous abortion (miscarriage) and complications of pregnancy.

Coverage for a mother and her newly born child shall be available for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Physician in consultation with the mother.

These maternity care benefits also apply to the natural mother of a newborn child legally adopted by you in accordance with the Healthplan adoption policies and Arizona law.

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Mental Health and Substance Abuse Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to mental health will not be considered to be charges made for treatment of mental health.

Substance Abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and

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treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of substance abuse.

Inpatient Mental Health Services

Services that are provided by a Participating Hospital for the treatment and evaluation of mental health.

Inpatient mental health benefits are exchangeable with partial hospitalization sessions when benefits are provided for not less than four (4) hours and not more than twelve (12) hours in any twenty-four (24) hour period. The benefit exchange will be two (2) partial hospitalization sessions are equal to one day of inpatient care.

Outpatient Mental Health Services

Services of Participating Providers who are qualified to treat mental health when treatment is provided on an outpatient basis in an individual, group or structured group therapy program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interferes with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic mental health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

Inpatient Substance Abuse Rehabilitation Services

Services provided by a facility designated by the Healthplan for rehabilitation when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs.

Outpatient Substance Abuse Rehabilitation Services

Services for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs including

outpatient rehabilitation in an individual, group, structured group or intensive outpatient structured therapy program.

Intensive outpatient structured therapy programs consist of distinct levels or phases of treatment that are provided by a certified/licensed substance abuse program. Intensive outpatient structured therapy programs provide nine or more hours of individual, family and/or group therapy in a week.

Substance Abuse Detoxification Services

Detoxification and related medical ancillary services when required for the diagnosis and treatment of addiction to alcohol and/or drugs. The Healthplan Medical Director will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Excluded Mental Health and Substance Abuse Services

The following are specifically excluded from mental health and substance abuse services:

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless medically necessary and otherwise covered under this agreement;
- Treatment of mental disorders that have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain;
- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders;
- Counseling for activities of an educational nature;
- Counseling for borderline intellectual functioning;
- Counseling for occupational problems;
- Counseling related to consciousness raising;
- Vocational or religious counseling;
- I.Q. testing;

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- Residential treatment;
- Custodial care, including but not limited to geriatric day care;
- Psychological testing on children requested by or for a school system.; and
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

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Medical Foods

Medical foods to treat inherited metabolic disorders. Metabolic disorders triggering medical food coverage are: (a) part of the newborn screening program as prescribed by Arizona statute; (b) involve amino acid, carbohydrate or fat metabolism; (c) have medically standard methods of diagnosis, treatment and monitoring including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues; and (d) require specifically processed or treated medical foods that are generally available only under the supervision and direction of a physician or a registered nurse practitioner, that must be consumed throughout life and without which the person may suffer serious mental or physical impairment.

We will cover the cost of medical foods prescribed to treat inherited metabolic disorders covered under this contract, subject to any applicable copayments, deductibles or coinsurance.

For the purpose of this section, the following definitions apply:

1. “Inherited Metabolic Disorder” means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under the newborn screening program as prescribed by Arizona statute.
2. “Medical Foods” means modified low protein foods and metabolic formula.
3. “Metabolic Formula” mean foods that are all of the following: (a) formulated to be consumed or administered enterally under the supervision of a medical doctor or doctor of osteopathy; (b) processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs; (c)

administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation; and (d) essential to a person’s optimal growth, health and metabolic homeostasis.

4. “Modified Low Protein Foods” means foods that are all of the following: (a) formulated to be consumed or administered enterally under the supervision of a medical doctor or doctor of osteopathy; (b) processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein; (c) administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrients requirements as established by medical evaluation; (d) essential to a person’s optimal growth, health and metabolic homeostasis.

Nutritional Evaluation

Nutritional evaluation and counseling from a Participating Provider when diet is a part of the medical management of a documented organic disease.

Obstetrical and Gynecological Services

Obstetrical and gynecological services that are provided by qualified Participating Providers for pregnancy, well-women gynecological exams, primary and preventive gynecological care and acute gynecological conditions. For these Services and Supplies you have direct access to qualified Participating Providers; you do not need a Referral from your PCP.

Transplant Services

Human organ and tissue transplant services at designated facilities throughout the United States. Transplant services include solid organ and bone marrow/stem cell procedures. This coverage is subject to the following conditions and limitations.

IV. Covered Services and Supplies

Transplant services include the recipient's medical, surgical and hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestinal, which includes small bowel, small bowel/liver or multivisceral.

All transplant services other than cornea, must be received at a qualified or provisional Cigna LIFESOURCE Transplant Network® facility.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor.

Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Transplant Travel Services

Reasonable travel expenses incurred by you in connection with a pre-approved organ/tissue transplant are covered subject to the following conditions and limitations. Transplant Travel benefits are not available for cornea transplants. Benefits for transportation, lodging and food are available to you only if you are the recipient of a pre-approved organ/tissue transplant from a designated Cigna LIFESOURCE Transplant Network® facility. The term recipient is defined to include a Member receiving authorized transplant related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Travel expenses for the Member receiving the transplant will include charges for:

- Transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility);
- Lodging while at, or traveling to and from the transplant site; and

- Food while at, or traveling to and from the transplant site.

In addition to you being covered for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver.

The following are specifically excluded travel expenses:

- Travel costs incurred due to travel within 60 miles of your home;
- Laundry bills;
- Telephone bills;
- Alcohol or tobacco products; and
- Charges for transportation that exceed coach class rates.

These benefits are only available when the Member is the recipient of an organ transplant. No benefits are available where the Member is a donor.

Oxygen

Oxygen and the oxygen delivery system. However, coverage of oxygen that is routinely used on an outpatient basis is limited to coverage within the Service Area. Oxygen Services and Supplies are not covered outside of the Service Area, except on an emergency basis.

Reconstructive Surgery

Reconstructive surgery or therapy that constitutes necessary care and treatment for medically diagnosed congenital defects and birth abnormalities for newborns, adopted children and children placed for adoption who were covered from birth, adoption or adoption placement. Additionally, reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement, which is accompanied by functional deficit (other than abnormalities of the jaw or related to TMJ disorder) provided that:

- the surgery or therapy restores or improves function or decreases risk of functional impairment; or

IV. Covered Services and Supplies

- reconstruction is required as a result of medically necessary, non-cosmetic surgery; or
- the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part.

Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the Healthplan Medical Director.

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10/07

Orthognathic Surgery

Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct; provided that:

- the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement, or;
- the orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease, or;
- the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

Repeat or subsequent orthognathic surgeries for the same condition are covered only when 1) the previous orthognathic surgery met the above requirements, and 2) there is a high probability of significant additional improvement as determined by the Healthplan Medical Director.

GSA-BEN(09).3

7/06

Preventive Care

Charges made for the following preventive care services (detailed information is available at www.healthcare.gov):

- (1) evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force;
- (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for

Disease Control and Prevention with respect to the Member involved;

- (3) for infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
- (4) for women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

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10/10

Short-term Rehabilitative Therapy

Short-term rehabilitative therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

The following limitation applies to short-term rehabilitative therapy:

- Occupational therapy is provided only for purposes of enabling Members to perform the activities of daily living after an illness or injury.

Short-term Rehabilitative Therapy services that are not covered include, but are not limited to:

- Sensory integration therapy; group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily-acted conditions without evidence of an underlying medical condition or neurological disorder;
- Treatment for functional articulation disorder, such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or injury; and
- Maintenance or preventive treatment consisting of routine, long-term or non-Medically Necessary care provided to prevent reoccurrences or to maintain the patient's current status.

Services that are provided by a chiropractic Physician are not covered. These services include the management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.

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1/07

Chiropractic Care Services

Diagnostic and treatment services utilized in an office setting by participating chiropractic Physicians and Osteopaths. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function. For these services you have direct access to qualified participating chiropractic Physicians and Osteopaths; you do not need a Referral from your PCP.

The following limitations applies to Chiropractic Care Services:

- Occupational therapy is provided only for purposes of enabling Members to perform the activities of daily living after an illness or injury.

The following are specifically excluded from chiropractic care services:

- Services of a Chiropractor or Osteopath which are not within his scope of practice, as defined by state law;
- Charges for care not provided in an office setting;
- Maintenance or preventive treatment consisting of routine, long-term or non-Medically Necessary care provided to prevent reoccurrences or to maintain the patient's current status, and
- Vitamin therapy.

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Section V. Exclusions And Limitations

Exclusions

Any Services and Supplies which are not described as covered in "Section IV. Covered Services and Supplies" or in an attached Rider or are specifically excluded in "Section IV. Covered Services and Supplies" or an attached Rider are not covered under this Agreement.

In addition, the following are specifically excluded Services and Supplies:

1. Care for health conditions that are required by state or local law to be treated in a public facility.
2. Care required by state or federal law to be supplied by a public school system or school district.
3. Care for military service disabilities treatable through governmental services if the Member is legally entitled to such treatment and facilities are reasonably available.
4. Treatment of an illness or injury which is due to war, declared or undeclared.
5. Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Agreement.
6. Assistance in the activities of daily living, including, but not limited to, eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
7. Any services and supplies for or in connection with experimental, investigational or unproven services.

Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be:

- Not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or
- Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate

regulatory agency to be lawfully marketed for the proposed use; or

- The subject of review or approval by an Institutional Review Board for the proposed use, except as provided in the "Cancer Clinical Trials" section of "Section IV. Covered Services and Supplies;" or
 - The subject of an ongoing clinical trial that meets the definition of a phase I, II or III clinical trial, except as provided in the "Cancer Clinical Trials" section of "Section IV. Covered Services and Supplies."
8. Cosmetic surgery, therapy or surgical procedures primarily for the purpose of altering appearance, except for necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance. The exclusions include surgical excision or reformation of any sagging skin on any part of the body, including, the eyelids, face neck, abdomen, arms, legs or buttocks; and services performed in connection with the enlargement, reduction, implantation, or change in appearance of portion of the body, including, the breast, face, lips, jaw, chin, nose, ears or genital; hair transplantation; chemical face peels or abrasion of the skin; electrolysis diplation; or any other surgical or non-surgical procedures which are primarily for the purpose of altering appearance. This does not exclude services or benefits that are primarily for the purpose of restoring normal bodily function, or surgery, which is medically necessary.
 9. The following services are excluded from coverage regardless of clinical indications:
 - Macromastia or Gynecomastia Surgeries;
 - Surgical treatment of varicose veins;
 - Abdominoplasty;
 - Panniculectomy;
 - Rhinoplasty;
 - Blepharoplasty;

V. Exclusions and Limitations

- Redundant skin surgery;
 - Removal of skin tags;
 - Acupressure;
 - Craniosacral/cranial therapy;
 - Dance therapy, movement therapy;
 - Applied kinesiology;
 - Rolfing;
 - Prolotherapy; and
 - Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
10. Treatment of TMJ disorder.
11. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
12. Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, including clinically severe (morbid) obesity, including: medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.
13. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including, employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
14. Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise covered under "Section IV. Covered Services and Supplies."
15. Infertility services, infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
16. Reversal of male and female voluntary sterilization procedures.
17. Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
18. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.
19. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
20. Non-medical counseling or ancillary services, including, but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, or mental retardation.
21. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including, but not limited to routine, long-term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
22. Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Inpatient Hospital Services", "Outpatient Facility Services", "Home Health Services", "Diabetic Services and Supplies", or "Breast Reconstruction and Breast

V. Exclusions and Limitations

- Prostheses” sections of "Section IV. Covered Services and Supplies."
23. Private hospital rooms and/or private duty nursing except as provided in the "Home Health Services" section of "Section IV. Covered Services and Supplies."
 24. Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.
 25. Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, hearing aids, dentures and wigs. Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, orthotics, elastic stockings, garter belts, corsets, dentures and wigs, except as provided in the "Diabetic Services and Supplies" provision of the "Covered Service and Supplies" section of the Agreement.
 26. Hearing aids, including, but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
 27. Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
 28. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
 29. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
 30. Treatment by acupuncture.
 31. All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in "Section IV. Covered Services and Supplies."
 32. Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
 33. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
 34. Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.
 35. Dental implants for any condition.
 36. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Healthplan Medical Director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
 37. Blood administration for the purpose of general improvement in physical condition.
 38. Cost of biologicals that are immunizations or medications for the purposes of travel, or to protect against occupational hazards and risks unless Medically Necessary or indicated.
 39. Cosmetics, dietary supplements and health and beauty aids.
 40. All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
 41. Expenses for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
 42. Telephone, e-mail and internet consultations and telemedicine.
 43. Massage Therapy.
- In addition to the provisions of this "Exclusions and Limitations" section, you will be responsible for payments on a fee-for-service basis for Services and Supplies under the conditions described in the "Reimbursement" provision of "Section VI. Other Sources of Payment for Services and Supplies."

Limitations

Circumstance Beyond the Healthplan's Control. To the extent that a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within our control results in our facilities, personnel, or financial resources being unavailable to provide or arrange for the provisions of a basic or supplemental health service or supplies in accordance with this Agreement, we will make a good faith effort to provide or arrange for the provision of the services or supplies, taking into account the impact of the event.

GSA-EXCL(01).1 AZ-D

6/09

Section VI. Other Sources of Payment for Services and Supplies

Workers' Compensation

Benefits under this Agreement will not duplicate any benefit which the Member is entitled to receive under workers' compensation law. In the event the Healthplan renders or pays for health services which are covered by a workers' compensation plan or included in a workers' compensation settlement. The Healthplan shall have the right to receive reimbursement either (1.) directly from the entity which provides Member's workers' compensation coverage; or (2.) directly from the Member to the extent, if any, that the Member has received payment from such entity, as follows:

1. Where the Healthplan has directly rendered or arranged for the rendering of services the Healthplan shall have a right o reimbursement to the extent of the Prevailing Rates for the care and treatment so rendered.
2. Where the Healthplan does not render services but pays for those services which are within the scope of the "Covered Services and Supplies" section of the Agreement. The Healthplan shall have a right of reimbursement to the extent that the Healthplan has made payments for the care and treatment so rendered.

In addition, it is the Member's obligation to fully cooperate with any attempts by the Healthplan to recover such expenses against the Member's employer in the event that coverage is not available as a result of the failure to the employer to take the steps required by law or regulation in connection with such coverage.

Medicare Benefits

Except as otherwise provided by federal law, the services and benefits under this Agreement for Members age sixty-five (65) and older, or for Members otherwise eligible for Medicare payments, shall not duplicate any services or benefits to which such Members are eligible under Parts A or B of the Medicare Act. Where Medicare is the responsible payor, all amounts payable pursuant to the Medicare program for services and benefits provided hereunder to Members are payable to and shall be retained by the Healthplan. Members enrolled in

Medicare shall cooperate with and assist the Healthplan in its efforts to obtain reimbursement from Medicare or the Member in such instances.

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Coordination of Benefits

This section applies if you are covered under another plan besides this health plan and determines how the benefits under the plans will be coordinated. If you are covered by more than one health benefit plan, you should file all claims with each plan.

A. Definitions

For the purposes of this section, the following terms have the meanings set forth below them:

Plan

Any of the following that provides benefits or services for medical care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured, which neither can be purchased by the general public nor is individually underwritten, including closed panel coverage;
- Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies;
- Medical benefits coverage of group, group-type, and individual automobile contracts.

Each type of coverage you have in these three (3) categories shall be treated as a separate Plan. Also, if a Plan has two parts and only one part has coordination of benefit rules, each of the parts shall be treated as a separate Plan.

Closed Panel Plan

A Plan that provides health benefits primarily in the form of services through a panel of employed or contracted providers and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays its benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines and may reduce its benefits after taking into consideration the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover the Reasonable Cash Value of any services it provided to you from the Primary Plan.

Allowable Expense

A necessary, customary, and reasonable health care service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you; but not including dental, vision or hearing care coverage. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

A plan which takes Medicare or similar government benefits into consideration when determining the application of its coordination of benefits provision does not expand the definitions of an Allowable Expense.

Claim Determination Period

A calendar year, but it does not include any part of a year during which you are not covered under this Agreement or any date before this section or any similar provision takes effect.

Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

B. Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent

with this section, the first of the following rules that applies to the situation is the one to use:

1. The Plan that covers you as a Subscriber or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
2. If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as a Subscriber or employee;
3. If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
 - a. first, if a court decree states that one parent is responsible for the child's health care expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
 - b. Then, the Plan of the parent with custody of the child;
 - c. Then, the Plan of the spouse of the parent with custody of the child;
 - d. Then, the Plan of the parent not having custody of the child, and
 - e. Finally, the Plan of the spouse of the parent not having custody of the child.
4. The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as a laid-off or retired employee (or as that employee's Dependent) shall be the Secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
5. The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a

result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

6. If one of the Plans that covers you is issued out of the state whose laws govern this Agreement and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended.

However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

C. Effect on the Benefits of this Agreement

If we are the Secondary Plan, we may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than one hundred (100%) percent of the total of all Allowable Expenses.

The difference between the benefit payments that we would have paid had we been the Primary Plan and the benefit payments that we actually paid as the Secondary Plan shall be recorded as a benefit reserve for you. We will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

As to each claim that is submitted, we shall determine the following:

1. Our obligation to provide Services and Supplies under this Agreement;
2. Whether a benefit reserve has been recorded for you; and
3. Whether there are any unpaid Allowable Expenses during the Claim Determination Period.

If there is a benefit reserve, we shall use the benefit reserve recorded for you to pay up to one hundred (100%) percent of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve shall return to zero (0) and a new benefit reserve shall be calculated for each new Claim Determination Period.

D. Recovery of Excess Benefits

If we provide Services and Supplies that should have been paid by the Primary Plan or if we provide services in excess of those for which we are obligated to provide under this Agreement, we shall have the right to recover the actual payment made or the Reasonable Cash Value of any services.

We shall have the sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments were made; any insurance company; health care Plan or other organization. If we request, you shall execute and deliver to us such instruments and documents as we determine are necessary to secure its rights.

E. Right to Receive and Release Information.

We, without consent of or notice to you, may obtain information from and release information to any Plan with respect to you in order to coordinate your benefits pursuant to this section. You shall provide us with any information we request in order to coordinate your benefits pursuant to this section.

F. Injuries Covered under Med Pay Insurance

If you are injured as a result of a motor vehicle accident, and the medical expenses are covered in full or part by a medical payment provision under an automobile insurance policy (Med Pay Insurance), the Med Pay Insurance shall pay first, and the Healthplan shall pay only in the event the amount of Med Pay Insurance is insufficient to pay for those medical expenses. The Healthplan reserves the right to require proof that Med Pay Insurance has paid the full amount required prior to making any payments. Payment for such services and benefits shall be your responsibility. If the Healthplan paid in excess of their obligation, you may be asked to

assist the Healthplan in obtaining reimbursement from Med Pay Insurance for expenses incurred in treating your injuries.

G. Health Care Provider Liens

Arizona law prohibits Participating Providers from charging you more than the applicable Copayment or other amount you are obligated to pay under this Agreement for covered services. However, Arizona law also entitles certain Participating Providers to assert a lien for their customary charges for the care and treatment of an injured person upon any and all claims of liability or indemnity, except health insurance. This means that if you are injured and have a claim against a non-health liability insurer (such as automobile or homeowner insurance) or any other payor source for injuries sustained, a Participating Provider may be entitled to a lien against available proceeds from any such insurer or payor in an amount equal to the difference between: (1) the applicable Member Copayment plus what the Participating Provider has received from Healthplan as payment for covered services, and (2) the Participating Provider's full billed charges.

VII. Termination of Your Coverage

Section VII. Termination of Your Coverage

We may terminate your coverage for any of the reasons stated below.

Termination By Reason of Ineligibility

When you fail to meet the eligibility criteria in “Section II. Enrollment and Effective Date of Coverage” as either a Subscriber or Dependent, your coverage under this Agreement shall cease. Coverage of all Members within a Membership Unit shall cease when the Subscriber fails to meet the eligibility criteria. The Group shall notify us of all Members who fail to meet the eligibility criteria.

Unless otherwise provided by law, if you fail to meet the eligibility criteria your coverage shall cease at midnight of the day that the loss of eligibility occurs, and we shall have no further obligation to provide Services and Supplies.

Termination By Termination of This Agreement

This Agreement may be terminated for any of the following reasons:

1. **Termination for Non-Payment of Fees.** We may terminate this Agreement for the Group’s non-payment of any Prepayment Fees owed to us.
2. **Termination on Notice.** The Group, without cause, may terminate this Agreement upon sixty (60) days prior written notice to us. We, without cause, may terminate this Agreement upon either: (i) ninety (90) days prior written notice to the Group of our decision to discontinue offering this particular type of coverage; or (ii) at the renewal date of the plan upon one hundred eighty (180) days prior written notice to the Group of our decision to discontinue offering all coverage in the applicable market. If coverage is terminated in accordance with (i) above, the Group may purchase a type of coverage currently being offered in that market.
3. **Termination for Fraud or Misrepresentation.** We may terminate this Agreement upon thirty (30) days prior written notice to the Group if, at any time, we determine that the

Group has performed an act or practice that constitutes fraud or has intentionally misrepresented a material fact.

4. **Termination for Violation of Contribution or Participation Rules.** We may terminate this Agreement upon sixty (60) days prior written notice to the Group if, after the initial twelve (12) month or other specified time period, it is determined that the Group is not in compliance with the participation and/or contribution requirements as established by us.
5. **Termination Due to Association Membership Ceasing.** If this Agreement covers an association, we may terminate this Agreement in accordance with applicable state or federal law as to a member of a bona fide association if the member is no longer a member of the bona fide association.

Termination Effective Date. Coverage under this Agreement shall terminate at midnight of the date of termination provided in the written notice, except in the case of termination for non-payment of fees, in which case this Agreement shall terminate immediately upon our notice to the Group.

Notice of Termination to Members. If this Agreement is terminated for reasons #1 or #3 in this section or for loss of eligibility, the Group shall notify you of the termination effective date. If this Agreement is terminated for any other reason by Cigna, we will notify you of the termination effective date. The Group will notify you of any applicable rights you may have under "Continuation of Coverage" section.

Responsibility for Payment. The Group shall be responsible for the payment of all Prepayment Fees due through the date on which coverage ceases. You shall be financially responsible for all services rendered after that date. The Group shall be responsible for providing appropriate notice of cancellation to all Members in accordance with applicable state law. If the Group fails to give written notice to you prior to such date, the Group shall also be financially responsible for, and shall submit to us, all Prepayment Fees due until such date as the Group gives proper notice.

VII. Termination of Your Coverage

Rescissions

Your coverage may not be rescinded (retroactively terminated) by the Healthplan or the plan sponsor unless: (1) the plan sponsor or an individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud; or (2) the plan sponsor or individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact.

Certification of Creditable Coverage Upon Termination

We will issue you a Certification of Creditable Group Health Plan Coverage as required by law and based on information provided to us by the Group at the following times:

1. When your coverage is terminated by reason of ineligibility or you otherwise become covered under “Section VIII. Continuation of Coverage”;
2. When your continuation coverage, if you elected to receive it, is exhausted; and
3. When you make a request within twenty-four (24) months after the date coverage expires under either of the above two situations; and
4. When you make a request while you are covered under this Agreement.

Extension of Benefits

We will provide an extension of benefits, subject to all terms and conditions of this Agreement, for a Member who is eligible for coverage and totally disabled on the date of discontinuance of this Agreement under the section entitled “Termination by Termination of this Agreement” above, if such Member became totally disabled while covered under this Agreement. This extension of benefits shall:

1. provide coverage that is Medically Necessary to treat the disabling condition; and
2. remain in effect until the earlier of the date:
 - (i) the Member is no longer totally disabled; or

(ii) the Member exhausts the maximum benefits available for treatment of the disabling condition; or

(iii) twelve (12) months after discontinuance of this Agreement.

“Totally disabled” means (for Subscriber or any Dependent who normally works for wage or profit), a medically determinable physical or mental impairment as the result of an injury or illness that renders such Member unable to perform any acts or duties necessary for Member’s own occupation, or any other employment or occupation for wage or profit for which Member is qualified by reason of education, training or experience, as determined by Healthplan Medical Director. In the case of any other Dependent, it means the continuing inability, as a result of injury or illness, to perform the normal activities or duties of individuals of like sex and age in good health, as determined by Healthplan Medical Director.

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Section VIII. Continuation of Coverage

Continuation of Group Coverage under COBRA

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or get a copy of the Plan Document from the Plan Administrator.

The Plan Administrator information is provided on the page titled "ERISA Summary Plan Description," if applicable. Please contact the Plan Administrator for the name, address and phone number of the Plan's COBRA Administrator.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the

Plan because either one of the following qualifying events happens:

- (1) Your hours of employment are reduced, or
- (2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- (1) Your spouse dies;
- (2) Your spouse's hours of employment are reduced;
- (3) Your spouse's employment ends for any reason other than his or her gross misconduct;
- (4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- (5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- (1) The parent-employee dies;
- (2) The parent-employee's hours of employment are reduced;
- (3) The parent-employee's employment ends for any reason other than his gross misconduct;
- (4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- (5) The parents become divorced or legally separated; or
- (6) The child stops being eligible for coverage under the Plan as a "dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, enrollment of

VIII. Continuation of Coverage

the employee in Medicare (Part A, Part B, or both), or, if the Plan provides retiree coverage, commencement of a proceeding in bankruptcy with respect to the Employer, the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to your Employer.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months from the date of the qualifying event.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months from the date of the qualifying event. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

If the Plan provides retiree health coverage

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan. Coverage will continue

until: (a) for you, your death; and (b) for your Dependent surviving spouse or Dependent child, up to 36 months from your death.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months from the date of the initial qualifying event. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the Plan Administrator. You must provide a copy of the Social Security Administration's determination. Termination of coverage for all covered persons during the additional 11 months will occur if the disabled person is found by the Social Security Administration to be no longer disabled. Termination for this reason will occur on the first day of the month beginning no more than 30 days after the date of the final determination. Please refer to "Early Termination of COBRA Continuation" below for additional circumstances under which COBRA continuation may terminate before the end of the maximum period of coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months from the initial qualifying event. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all of these cases, you must**

VIII. Continuation of Coverage

make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator.

Early Termination of COBRA Continuation

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, if a covered employee enrolls in Medicare, or if the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

Cost of COBRA Continuation Coverage

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150%). If you or your dependents experience a qualifying event, the Plan Administrator will send you a notice of continuation rights, which will include the required premium.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282.

TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at

www.doleta.gov/tradeact/2002act_index.asp.

Conversion Available Following Continuation

If the Plan provides for a conversion privilege, the plan must offer this option within 180 days following the maximum period of continuation. However, no conversion will be provided if the qualified beneficiary does not maintain COBRA continuation coverage for the maximum allowable period or does not otherwise meet the eligibility requirements for a conversion plan.

Service Area Restrictions

This plan includes a service area restriction which requires that all enrolled participants and beneficiaries receive services in the Employer's service area. This restriction also applies to COBRA continuation coverage. If you or your Dependents move outside the Employer's service area, COBRA continuation coverage under your current plan in your new location will be limited to emergency services only. To obtain coverage for non-emergency services, you must obtain such services from a network provider in the Employer's service area. If your Employer offers other benefit options that are available in your new location, you may be allowed to obtain COBRA continuation coverage under that option. If you or your Dependent is moving outside the Employer's service area, please contact your Employer for information on the availability of other plan options.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

IMPORTANT NOTICE

COBRA BENEFITS WILL ONLY BE ADMINISTERED ACCORDING TO THE TERMS OF THE CONTRACT. THE HEALTHPLAN WILL NOT BE OBLIGATED TO ADMINISTER OR FURNISH ANY COBRA BENEFITS AFTER THE CONTRACT HAS TERMINATED.

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Conversion to Non-Group (Individual) Coverage

If you have properly elected and completed any COBRA continuation or other continuation coverage (i.e. completed the maximum coverage period under the continuation coverage), you may apply to the Healthplan for conversion to non-group (individual) coverage. If you do not elect, fail to properly elect or fail to complete any COBRA continuation coverage or other continuation coverage for which you are eligible, conversion to non-group coverage is not available to you.

You must continue to reside in the Service Area in order to be eligible for non-group (individual) coverage. You may apply for non-group (individual) coverage as follows:

A. Conversion After Loss of Subscriber Eligibility

If you, as the Subscriber, are no longer eligible for coverage under this Agreement for any reason other than the reasons stated in the “Termination of Agreement” provisions of “Section VII. Termination of Your Coverage,” you may apply for conversion to non-group (individual) coverage. You must apply and pay the applicable Prepayment Fee within thirty-one (31) days of the loss of group coverage. At the time of conversion to non-group (individual) coverage, you may also apply for non-group (individual) coverage for Dependents who were Members at the time of your loss of eligibility. If your application and all non-group fees, including all fees for the period since the termination of group coverage, are submitted within thirty-one (31) days of the loss of group coverage your non-group (individual) coverage will be effective as of the date of such termination.

B. Conversion Upon Death or Divorce of Subscriber

If you are a Dependent who has lost eligibility for coverage under this Agreement due to the death or divorce of the Subscriber, you may apply for conversion to non-group (individual) coverage under the provisions of paragraph A of this section.

C. Conversion Upon Meeting Age Limitation

If you are a Dependent who has lost eligibility for coverage under this Agreement due to your attainment of an age limitation identified in the Agreement, you may apply for conversion to non-group (individual) coverage under the provisions of paragraph A of this section.

D. Conversion After Expiration of COBRA or Other Continuation Coverage

A Member whose COBRA or other continuation coverage has expired after the maximum coverage period may apply for conversion to non-group (individual) coverage under the provisions of paragraph A of this section.

The Service and Supplies, terms and conditions of the non-group (individual) coverage, including premiums, Copayments and deductibles, if any, shall be in accordance with the rules of Healthplan in effect at the time of conversion and will not necessarily be identical to the Service and Supplies provided under this Agreement.

Continuation of Coverage Under FMLA

If the Group is subject to the requirements of FMLA (the federal law known as the Family and Medical Leave Act of 1993, as amended), the Subscriber shall have coverage under this Agreement during a leave of absence if the Subscriber is an eligible employee under the terms of FMLA and the leave of absence qualifies as a leave of absence under FMLA.

VIII. Continuation of Coverage

In such a case, the Subscriber shall pay to the Group the portion of the Prepayment Fee, if any, that the Subscriber would have paid had the Subscriber not taken leave and the Group shall pay the Healthplan the Prepayment Fee for the Subscriber as if the Subscriber had not taken leave.

You and your Dependents will be subject to only the balance of a Pre-existing Conditions Limitation (PCL) or waiting period, if any, that was not yet satisfied before the leave began. However, if an injury or sickness occurs or is aggravated during the military leave, full plan limitations will apply.

Any 63-day break in coverage rule regarding credit for time accrued toward a PCL waiting period will be waived.

NOTICE OF FEDERAL REQUIREMENTS - UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

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The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to military leaves of absence. These requirements apply to medical coverage for you and your Dependents.

Continuation of Coverage

You may continue coverage for yourself and your Dependent as follows:

You may continue benefits, by paying the required premium to your employer, until the earliest of the following:

- 24 months from the last day of employment with the employer;
- the day after you fail to apply or return to work; and
- the date the policy cancels.

Your employer may charge you and your Dependents up to 102% of the total premium.

Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to any "Conversion Privilege" shown in your certificate.

Reinstatement of Benefits

If your coverage ends during the leave because you do not elect USERRA, or an available conversion plan at the expiration of USERRA, and you are reemployed by your current employer, coverage for you and your Dependents may be reinstated if, (a) you gave your employer advance written or verbal notice of your military service leave, and (b) the duration of all military leaves while you are employed with your current employer does not exceed 5 years.

Section IX. Miscellaneous**Additional Programs**

We may, from time to time, offer or arrange for various entities to offer discounts, benefits or other consideration to our Members for the purpose of promoting the general health and well being of our Members. We may also arrange for the reimbursement of all or a portion of the cost of services provided by other parties to the Group. Contact the Healthplan Member Services for a list of currently available programs, participating businesses, and other details regarding such arrangements. These programs may include discounts on the following types of services:

- Health Club/GYM Memberships
- Tai-Chi Classes
- Weight Loss Program
- Alternative Care, including Massage Therapy
- Health Food Stores
- Over the Counter Medications
- Vision Products and Services
- Hearing Aids and Services
- Wellness Classes-Selected classes may be offered to our Members for a copayment at participating Cigna HealthCare Centers
- Cigna HealthCare Healthy Babies Program[®]

These programs are provided for the benefit of Cigna HealthCare Members, and are not an endorsement of the services or vendors listed. Discounts are subject to change or elimination upon sixty (60) days' prior notice.

Administrative Policies Relating to this Agreement

We may adopt reasonable policies, procedures, rules and interpretations that promote orderly administration of this Agreement.

Assignability

The benefits under this Agreement are not assignable unless agreed to by the Healthplan. When Covered Services and Supplies are received by the Subscriber or Subscriber's covered

dependents from a non-participating provider, the Healthplan will either reimburse the Subscriber, or in the event of an assignment of benefits, make payment to the non-participating provider, for such Covered Services and Supplies in accordance with the terms of this Agreement. In the case of Emergency Services rendered by a non-participating provider or other network exception as defined by Arizona law, Healthplan shall assure that the Subscriber's financial responsibility is limited to the applicable copayment, coinsurance or deductible for the Covered Services and Supplies that would have applied had the services been rendered in-network by a participating provider. In the case of Emergency Services rendered by a non-participating provider where the Subscriber has already made a payment to the non-participating provider, such assurance means that Healthplan would reimburse the Subscriber for any payment made, to the extent that it exceeds the Subscriber's financial responsibility for the applicable copayment, coinsurance or deductible.

Clerical Error

No clerical error on the part of the Healthplan shall operate to defeat any of the rights, privileges or benefits of any Member.

Entire Agreement

This Agreement constitutes the entire Agreement between the Healthplan, the Group, and Members and supersedes any previous agreement. Only an officer of the Healthplan has authority to waive any conditions or restrictions of this Agreement, extend the time for making payment, or bind the Healthplan by making any promise or representation, or by giving or receiving any information. No change in the Agreement shall be valid unless stated in a Rider or an amendment attached hereto signed by an officer of the Healthplan. In the event of any direct conflict between information contained in the Group Service Agreement and other collaterals, the terms of the Group Service Agreement shall govern.

No Implied Waiver

Failure by the Healthplan, the Group, or a Member to avail themselves of any right conferred by this Agreement shall not be construed as a waiver of that right in the future.

Notice

The Healthplan, the Group, and the Member shall provide all notices under this Agreement in writing, which shall be hand-delivered or mailed, postage pre-paid, through United States Postal Service to the addresses set forth on the Cover Sheet.

Records

The Healthplan maintains records regarding Members, but the Healthplan shall not be liable for any obligation dependent upon information from the Group prior to receipt by the Healthplan in a form satisfactory to the Healthplan. Incorrect information furnished by the Group may be corrected, if the Healthplan shall not have acted to its prejudice by relying on it. All records of the Group and the Healthplan that have a bearing on coverage of a Member shall be open for review by the Healthplan, the Group or the Member at any reasonable time.

Service Marks

The Cigna HealthCare 24 Hour Health Information LineSM and Cigna Lifesource Organ Transplant Network[®] are registered service marks of Cigna Corporation.

Severability

If any term, provision, covenant or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of this Agreement shall remain in full force and effect and shall in no way be affected, impaired, or invalidated.

Successors and Assigns

This Agreement shall be binding upon and shall inure to the benefit of the successors and assigns of the Group and the Healthplan, but shall not be assignable by any Member.

Schedule of Copayments

THIS DEDUCTIBLE PROVISION IS A SUPPLEMENT TO THE SCHEDULE OF COPAYMENTS.

It is recommended that you review your Group Service Agreement for an exact description of the Services and Supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

The **Individual Deductible** is the amount you are responsible for paying out-of-pocket, each Contract Year, for covered Services and Supplies (as identified in the Group Service Agreement). You must meet your Individual Deductible before the Healthplan begins to pay the cost associated with your coverage. However, when the amount paid by individuals in your Membership Unit to meet their Individual Deductibles equals the **Family Deductible** amount, all Members in the Membership Unit will be considered to have met their Individual Deductible for that Contract Year.

The following are not subject to the Deductible provisions. Copayments do not apply to the Deductible.

- Office visits
- Inpatient professional charges
- Outpatient professional charges
- Emergency and urgent care services
- Ambulance services
- Durable medical equipment
- External prosthetic appliances
- Home health care services
- G. Hospice outpatient services

The Deductible does not apply to the Total Copayment Maximum. The Individual and Family Deductible amounts are identified below.

Individual Deductible	\$500
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Family Deductible	\$1000
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Schedule of Copayments

THIS SCHEDULE OF COPAYMENTS IS A SUPPLEMENT TO THE GROUP SERVICE AGREEMENT PROVIDED TO YOU AND IS NOT INTENDED AS A COMPLETE SUMMARY OF THE SERVICES AND SUPPLIES COVERED OR EXCLUDED.

It is recommended that you review your Group Service Agreements for an exact description of the Services and Supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Plan Deductible - The plan deductible amount and how it applies to Covered Services and Supplies is described on the separate Deductible provision page.

Covered Services and Supplies	Copayments
<p>Physician Services</p> <p>Primary Care Physician Office Visit</p>	<p>\$25 Copayment per office visit</p> <p>The office visit Copayment will be waived when immunization is the only service provided</p> <p>The office visit Copayment will be waived for allergy injections (includes allergy serum)</p>
<p>Specialty Care Physician Office Visit Office Visits</p> <p>Surgery Performed in the Physician's Office</p>	<p>\$40 Copayment per office visit</p> <p>The office visit Copayment will be waived for allergy injections (includes allergy serum)</p>
<p>Preventive Care Services</p> <p>Well-Baby Care</p> <p>Well-Child Care</p> <p>Adult Care</p> <p>Well-Woman Care</p>	<p>No Charge</p>

<p>Inpatient Hospital Services</p> <p>Semi Private Room and Board Physician and Surgeon Charges Laboratory, Radiology and other Diagnostic and Therapeutic Services Administered Drugs, Medications, Biologicals and Fluids Special Care Units Operating Room, Recovery Room Anesthesia Inhalation Therapy Radiation Therapy and Chemotherapy</p>	<p>No Charge after plan deductible</p>
<p>Outpatient Facility Services</p> <p>Operating Room, Recovery Room, Procedures Room, and Treatment Room including Physician Services Laboratory and Radiology Services Administered Drugs, Medications, Biologicals and Fluids Anesthesia Inhalation Therapy</p>	<p>No Charge after plan deductible</p>
<p>Emergency and Urgent Care Services</p> <p>Physician's Office</p> <p>Hospital Emergency Room</p> <p>Urgent Care Facility or Outpatient Facility</p>	<p>Same as Physician Office Visit Copayment</p> <p>\$200 Copayment per visit</p> <p>The emergency room Copayment will be waived if you are admitted to a participating hospital directly from the emergency room</p> <p>\$75 Copayment per visit</p> <p>The urgent care facility Copayment will be waived if you are admitted to a participating hospital directly from the urgent care facility.</p>
<p>Ambulance Services</p>	<p>No Charge</p>

Diabetic Services and Supplies	
Self Management Courses and Training	Same as Physician Office Visit Copayment
Equipment	Same as Durable Medical Equipment Copayment per item
Insulin and other Diabetic Pharmaceutical Supplies	Same as Prescription Drug Copayment
Durable Medical Equipment	No Charge
External Prosthetic Appliances	No Charge
Family Planning Services	
Office Visits (Tests, Counseling)	Same as Physician Office Visit Copayment
Surgical Sterilization Procedures	Same as Inpatient Hospital, Outpatient Facility or Physician Office Visit Copayment, depending on facility used
Hearing Exam 1 exam per contract year	Same as Physician Office Visit Copayment
Home Health Services 100 day maximum per member per contract year, Maximum of 16 hours in total per day	No Charge
Hospice Services	
Inpatient Services	No Charge
Outpatient Services	No Charge
Inpatient Services at Other Participating Health Care Facilities 60 day maximum per Member per Contract Year	
Rehabilitation Hospital	No Charge
Skilled Nursing Facility and Sub-Acute Facilities	No Charge

Outpatient Laboratory and Radiology Services Advanced Radiological Imaging (MRIs, MRAs, CAT scans, PET scans, etc.) Other Laboratory and Radiology Services Outpatient Hospital Facility Independent Facility	No Charge after plan deductible No Charge after plan deductible No Charge
Mammography	Place of Service Copayment Applies
Maternity Care Services Initial Office Visit to Confirm Pregnancy All other Office Visits Delivery	Same as Physician Office Visit Copayment No Charge Same as Inpatient Hospital Copayment
Medical Foods	50% of Charge; limited to an annual maximum of \$5,000
Mental Health and Substance Abuse Services** Inpatient Mental Health Services Outpatient Individual Mental Health Services <i>Deductible, if any, does not apply.</i> Outpatient Mental Health Group Therapy <i>Deductible, if any, does not apply.</i> Mental Health Intensive Outpatient Therapy Programs <i>Deductible, if any, does not apply.</i> Inpatient Substance Abuse Rehabilitation Services	Same as Inpatient Hospital No Charge No Charge No Charge Same as Inpatient Hospital

<p>Outpatient Individual Substance Abuse Rehabilitation Services <i>Deductible, if any, does not apply.</i></p> <p>Substance Abuse Intensive Outpatient Therapy Programs <i>Deductible, if any, does not apply.</i></p> <p>Inpatient Substance Abuse Detoxification Services</p>	<p>No Charge</p> <p>No Charge</p> <p>Same as Inpatient Hospital</p>
<p>Outpatient Substance Abuse Detoxification Therapy <i>Deductible, if any, does not apply.</i></p>	<p>No Charge</p>
<p>Nutritional Evaluation 3 visit maximum per Member per Contract Year</p>	<p>Same as Physician Office Visit Copayment</p>
<p>Transplant Travel Services Maximum Maximum \$10,000</p>	
<p>Short-term Rehabilitative Therapy , Cardiac Rehabilitation Services Services provided on an outpatient basis are limited to 60 day maximum per Member per Contract Year</p>	<p>Same as Physician Office Visit Copayment</p>
<p>Chiropractic and Osteopathic Care Services Services provided on an outpatient basis are limited to a 20 day maximum per Member per Contract Year</p>	<p>Same as Physician Office Visit Copayment</p>

Total Copayment Maximum *	
Individual Member Total Copayment Maximum	\$3,000 per Contract Year
Membership Unit Total Copayment Maximum	\$9,000 per Contract Year

*Only Copayments identified in this Schedule of Copayments or the Supplemental Prescription Drug Rider which have been paid by a Member for Prescription Drugs, Inpatient Services, Outpatient Facility Services, Inpatient Services at Other Participating Health Care Facilities, Advanced Radiological Imaging (MRI, MRA, PET, CAT scans) Inpatient Mental Health Services, Inpatient Substance Abuse Rehabilitation and Inpatient Detoxification Services apply to these maximums.

**Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized and will not count toward any plan limits that are shown in the Schedule for mental health and substance abuse services including in-hospital services. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance abuse expense will be determined by the Healthplan Medical Director in accordance with the applicable mixed services claim guidelines.

Amendment to the Group Service Agreement

Group: City of Tucson

Amendment Effective Date: July 1, 2013

The following language has been removed from the Group Service Agreement, Section V: Exclusions and Limitations:

- Treatment of TMJ disorder.

The following change is made to the Group Service Agreement, Section V: Exclusions and Limitations:

Surgical treatment of varicose veins is not excluded when such treatment is Medically Necessary.

The following language has been added to the Group Service Agreement, Section V: Exclusions and Limitations following the exclusion for Obesity Surgery and Treatment (Bariatric) Services:

This exclusion shall not apply in the event that a Member received bariatric or laproscopic band surgical services under a Cigna HealthCare Group Service Agreement issued to Group during the period from July 1, 2007 through June 30, 2009. In that case, such Members will be covered for any Medically Necessary treatment of a complication of the surgery, post operative physician visits, periodic adjustment of the laproscopic band, and a second gastric bypass surgery in the event of failure of the first surgery that is not due to Member's noncompliance.

In the Group Service Agreement, Section II: Enrollment and Effective Date of Coverage, under subsection titled "Who Can Enroll as a Member, part C., the following language replaces numbers 1 through 7:

1. Please refer to the Employee Handbook for specific information about Domestic Partner Coverage.

In the Group Service Agreement, Section II: Enrollment and Effective Date of Coverage, under subsection titled "Enrollment and Effective Date of Coverage, part B., the enrollment timeframe for a newborn is changed from thirty-one (31) days to sixty (60) days.

This Amendment takes effect on the amendment effective date shown above, subject to all the provisions of the Group Service Agreement.

Supplemental Rider

This Supplemental Rider is a part of the Cigna HealthCare of Arizona, Inc. Group Service Agreement ("the Agreement") and subject to all of the terms, conditions and limitations contained therein. In consideration for an additional monthly fee incorporated into the Prepayment Fee, the following supplemental Prescription Drug benefit is added to the Agreement.

Prescription Drugs

I. Definitions

Copayment means the amount shown in the Prescription Drug Schedule of Copayments that you pay for certain Covered Services and Supplies. The Copayment may be a fixed dollar amount or a percentage of the amount Cigna charges the Group with respect to the Covered Service or Supply.

Prescription Drug List means a listing of approved Prescription Drugs, and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with the parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

Participating Pharmacy means 1) a retail pharmacy with which the Healthplan has contracted to provide prescription services to Members, or 2) a designated mail order pharmacy with which the Healthplan has contracted to provide mail order prescription services to Members.

Pharmacy & Therapeutics (P&T) Committee. A committee of Cigna HealthCare Participating Providers, Medical Directors and Pharmacy Directors which regularly reviews Prescription Drugs and Related Supplies for safety and efficacy. The P&T Committee evaluates Prescription Drugs and Related Supplies for potential addition to or deletion from the Prescription Drug List and may also set dosage and/or dispensing limits on Prescription Drugs and Related Supplies.

Prescription Drug means (i) a drug which has been approved by the Food and Drug Administration for safety and efficacy, (ii) certain drugs approved under the Drug Efficacy Study Implementation review or (iii) drugs marketed prior to 1938 and not subject to

review, and which can, under federal or state law, be dispensed only pursuant to a prescription order.

Prescription Order means the lawful authorization for a Prescription Drug or Related Supply by a Physician who is duly licensed to make such authorization within the course of such Physician's professional practice or each authorized refill thereof.

Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under this Prescription Drug benefit and spacers for use with oral inhalers.

II. Services and Benefits

Subject to the provisions of this Rider and the Agreement, Healthplan will cover those Medically Necessary Prescription Drugs and Related Supplies, ordered by a Physician and purchased from Participating Pharmacies as designated by Healthplan. Healthplan will also cover Medically Necessary Prescription Drugs and Related Supplies dispensed by a Participating Pharmacy, with a prescription issued to a Member by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When a Member is issued a prescription for a Prescription Drug or Related Supply as part of the rendering of Emergency Services and a Participating Pharmacy cannot reasonably fill such prescription, such prescription will be covered by Healthplan, subject to the provisions of this rider.

III. Limitations

Each Prescription Order or refill shall be limited as follows:

- to up to a consecutive thirty (30) day supply at a retail Participating Pharmacy, unless limited by the drug manufacturer's packaging; or
- to up to a consecutive ninety (90) day supply at a mail order Participating Pharmacy, unless limited by the drug manufacturer's packaging; or
- to a dosage and/or dispensing limit as determined by the P&T Committee.

Coverage for certain Prescription Drugs and Related Supplies require your Physician to obtain prior authorization prior to prescribing. Prior authorization may include, for example, a step

therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If your Physician wishes to request coverage for a Prescription Drug or Related Supply for which prior authorization is required, your Physician may call or complete the appropriate prior authorization form and fax it to Cigna HealthCare to request prior authorization for coverage of the Prescription Drug or Related Supply. Your Physician should make this request before writing the prescription.

If the request is approved, your Physician will receive confirmation. The authorization will be processed in our claim system to allow you to have coverage for this Prescription Drug or Related Supply. The length of the authorization will depend on the diagnosis and Prescription Drug or Related Supply. When your Physician advises you that coverage for the Prescription Drug or Related Supply has been approved, you should contact the Participating Pharmacy to fill the prescription(s).

If the request is denied, your Physician and you will be notified that coverage for the Prescription Drug or Related Supply is not authorized.

If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the Agreement, by submitting a written request stating why the Prescription Drug or Related Supply should be covered.

If you have questions about a prior authorization request, you should call Member Services at the toll-free number on the Cigna HealthCare ID card.

All newly approved Food and Drug Administration (FDA) drugs are designated as either non-preferred or non-Prescription Drug List drugs until the P&T Committee evaluates the Prescription Drug clinically for a different designation. Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.

IV. Member Payments

Coverage for Prescription Drugs and Related Supplies is subject to a Copayment. The applicable Copayments are identified in the Prescription Drug Schedule of Copayments. In no event will the Copayment exceed the retail cost of the Prescription Drug or Related Supply.

When a treatment regimen contains more than one type of Prescription Drug which are packaged together for the convenience of the Member, a Copayment will apply to each Prescription Drug.

V. Exclusions

Except as otherwise set forth in this Rider, coverage for Prescription Drugs and Related Supplies is subject to the exclusions and limitations set forth in the "Exclusions and Limitations" Section of the Agreement. In addition, any services or benefits related to Prescription Drugs and Related Supplies, which are not described in this Supplemental Rider, are excluded from coverage under the Agreement. By way of example, but not of limitation, the following are specifically excluded services and benefits:

1. Any drugs available over the counter that do not require a prescription by Federal or State Law, and any drug that is a pharmaceutical alternative to an over the counter drug other than insulin.
2. Any drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee.
3. Any injectable drugs including injectable infertility drugs. However, self-administered injectables on the Prescription Drug List which are used to treat diabetes, acute migraine headaches, anaphylactic reactions, vitamin deficiencies and injectables used for anticoagulation are covered. However, upon prior authorization by Healthplan Medical Director, injectable drugs may be covered subject to the required Copayment.
4. Any drugs that are experimental or investigational, within the meaning set forth in the Agreement.
5. Food and Drug Administration (FDA) approved drugs used for purposes other than those

approved by the FDA unless the drug is recognized as safe and effective for the treatment of the particular indication in one of the standard reference compendia (drug information for the healthcare provider, The United States Pharmacopoeia Drug Information, or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal.

6. Any prescription and non-prescription supplies (such as, ostomy supplies), devices, and appliances other than Related Supplies.
7. Any prescription contraceptive drug or device approved by the United States Food and Drug Administration upon request of a religious employer for which use of contraceptives conflicts with the religious employer's beliefs and practices. This does not exclude coverage for prescription contraceptive methods ordered by a Participating Physician with prescriptive authority for medical indications other than to prevent an unintended pregnancy.
8. Implantable contraceptive products, except as covered in the Agreement.
9. Any fertility drug.
10. Any drugs used for treatment of sexual dysfunction, including erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido.
11. Any prescription vitamins (other than pre-natal vitamins), dietary supplements and fluoride products.
12. Drugs used for cosmetic purposes, such as, drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products.
13. Any diet pills or appetite suppressants (anorectics).
14. Prescription smoking cessation products.
15. Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.
16. Replacement of Prescription Drugs and Related Supplies due to loss or theft.
17. Drugs used to enhance athletic performance.
18. Drugs which are to be taken by or administered to a Member while the Member is a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.
19. Prescriptions more than one year from the original date of issue.

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(7/12) City of Tucson

Prescription Drug Schedule of Copayments

Type of Drug	Copayments	
	Retail Participating Pharmacy Copayment (applies to each 30 day supply.)	Mail Order Pharmacy Copayment (applies to each 90 day supply.)
Generic* drugs on the Prescription Drug List	maximum copayment –\$15	maximum copayment – \$30
Name Brand* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	maximum copayment – \$40	maximum copayment – \$80
Name Brand* drugs on the Prescription Drug List with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	maximum copayment – \$60	maximum copayment – \$120

* Designated as per generally-accepted industry sources and adopted by Healthplan

FEDERAL REQUIREMENTS

The following pages explain your rights and responsibilities under certain federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this agreement, the provision which provides the better benefit will apply.

Coverage of Students on Medically Necessary Leave of Absence

If your Dependent child is covered by this plan as a student, coverage will remain active for that child if the child is on a medically necessary leave of absence from a postsecondary educational institution (such as a college, university or trade school).

Coverage will terminate on the earlier of:

- (a) The date that is one year after the first day of the medically necessary leave of absence; or
- (b) The date on which coverage would otherwise terminate under the terms of the plan.

The child must be a Dependent under the terms of the plan and must have been enrolled in the plan on the basis of being a student at a postsecondary educational institution immediately before the first day of the medically necessary leave of absence.

The plan must receive written certification from the treating physician that the child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

A “medically necessary leave of absence” is a leave of absence from a postsecondary educational institution, or any other change in enrollment of the child at the institution that: (1) starts while the child is suffering from a serious illness or condition; (2) is medically necessary; and (3) causes the child to lose student status under the terms of the plan.

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Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)

If you or your eligible Dependent(s) experience a special enrollment event as described below, you or your eligible Dependent(s) may be entitled to enroll in the Plan outside of a designated enrollment period upon the occurrence of one of the special enrollment events listed below. If you are already enrolled in the Plan, you may request enrollment for you and your eligible Dependent(s) under a different option offered by the Employer for which you are currently eligible. If you are not already enrolled in the Plan, you must request special enrollment for yourself in addition to your eligible Dependent(s). You and all of your eligible Dependent(s) must be covered under the same option. The special enrollment events include:

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan: Employee only; spouse only; Employee and spouse; Dependent child(ren) only; Employee and Dependent child(ren); Employee, spouse and Dependent child(ren). Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage. Dependent children who were already Dependents of the Employee but not currently enrolled in the Plan are not entitled to special enrollment.
- **Loss of eligibility for State Medicaid or Children’s Health Insurance Program (CHIP).** If you and/or your Dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.
- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible

Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:

- divorce or legal separation;
- cessation of Dependent status (such as reaching the limiting age);
- death of the Employee;
- termination of employment;
- reduction in work hours to below the minimum required for eligibility;
- you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
- you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
- the other plan no longer offers any benefits to a class of similarly situated individuals.
- **Termination of employer contributions (excluding continuation coverage).** If a current or former employer ceases all contributions toward the Employee's or Dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).
- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: (a) due to failure of the employer or other responsible entity to remit premiums on a timely basis; (b) when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan; or (c) when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.
- **Eligibility for employment assistance under State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

Except as stated above, special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective on the first day of the calendar month following receipt of the request for special enrollment.

If your plan contains out-of-network benefits, individuals within that plan who enroll due to a special enrollment event will not be considered Late Entrants. Any Pre-existing Condition limitation will be applied upon enrollment, reduced by prior Creditable Coverage, but will not be extended as for a Late Entrant.

Domestic Partners and their children (if not legal children of the Employee) are not eligible for special enrollment.

Effect of Section 125 Tax Regulations on This Plan

If your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash (salary).

A. Coverage Elections

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if your Employer agrees and you enroll for or change coverage within 30 days of the following:

- the date you meet the Special Enrollment criteria described above; or
- the date you meet the criteria shown in the following Sections B through F.

B. Change of Status

A change in status is defined as:

1. change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
2. change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
3. change in employment status of Employee, spouse or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
4. changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
5. change in residence of Employee, spouse or Dependent to a location outside of the Employer's network service area; and
6. changes which cause a Dependent to become eligible or ineligible for coverage.

C. Court Order

A change in coverage due to and consistent with a court order of the Employee or other person to cover a Dependent.

D. Medicare or Medicaid Eligibility/Entitlement

The Employee, spouse or Dependent cancels or reduces coverage due to entitlement to Medicare or Medicaid, or enrolls or increases coverage due to loss of Medicare or Medicaid eligibility.

E. Change in Cost of Coverage

If the cost of benefits increases or decreases during a benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution.

When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

F. Changes in Coverage of Spouse or Dependent Under Another Employer's Plan

You may make a coverage election change if the plan of your spouse or Dependent: (a) incurs a change such as adding or deleting a benefit option; (b) allows election changes due to Special Enrollment, Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or (c) this Plan and the other plan have different periods of coverage or open enrollment periods.